INDIANA HEALTH COVERAGE PROGRAMS

Long Term Care Operating Procedures Manual

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Address any comments concerning the contents of this manual to:

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Revision History

Document Version Number	Revision Date	Revision Page Number(s)	Reason for Revisions	Revisions Completed By
Version 1.0	May 2001	All	Updated procedures and formatted document	Karen Girgis

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Section 1: Departmental Organization and Staffing

Long Term Care Statistical Analyst Job Description

The Long Term Care (LTC) statistical analyst researches and develops a variety of reports independently or collaboratively with the Office of Medicaid Policy and Planning (OMPP) relating to the LTC program in the Indiana Health Coverage Programs (IHCP). In addition, the analyst maintains information derived from on-site LTC review audits.

Long Term Care Statistical Analyst Qualifications

- Minimum two years experience with the IHCP, preferably in the LTC area
- Strong working knowledge of Indiana*AIM*
- Working knowledge of Microsoft® Excel worksheet and Microsoft Access database programs

Job Specific Skills and Essential Functions

Communication

- Communicates goals, assignments, audits, and expectations in a concise, organized and effective manner, both orally and in writing
- Interacts with providers—from initial phone call to exit conference—as well as team members and internal EDS departments

Customer Skills

- Develops and maintains an awareness of customer requirements and expectations
- Maintains knowledge of complete audit process
- Aware of ongoing changes in the IHCP as well as changes in priorities and the impact on the provider community
- Disseminates new information to providers
- Demonstrates strong customer service commitment
- Maintains familiarity with federal and state regulations and how to access them
- Identifies problem areas, offers solutions, and educates providers
- Identifies overall concerns during the audit process and follows up on identified situation or refers to management appropriately

	• Offers suggestions or ideas to streamline or improve internal processes and procedures
Flexibility/ Adaptability	• Works effectively with all team members
	• Comprehends and implements customer changes promptly
	• Prepares schedules to meet the audit requirements, minimize costs, and meet team member needs
	• Incorporates schedule changes with minimal disruption
	• Accepts additional responsibilities in the office
	• Offers alternative solutions
Business Skills	• Prepares accurate and timely expense reports
	• Identifies areas for internal cost reduction
	• Submits referrals for possible abuse or fraud situations
	• Maintains knowledge of internal resources and responsibilities
	• Maintains basic knowledge of Indiana*AIM* and basic computer skills
	• Demonstrates organizational ability in work, regardless of circumstances
	• Anticipates schedule problems and avoids if possible
	• Maintains high quality in balance with quantity
	• Maintains professional demeanor at all times
Teamwork	• Interacts successfully with all team members to accomplish LTC review
	• Contributes actively to all phases of LTC work flow as needed
	• Respects and listens to co-workers and shares information and concerns
	• Develops a working relationship by respecting personal differences
Leadership	• Takes ownership of own work and team's work
	• Displays initiative by willingly taking on additional assignments
	• Volunteers for opportunities to learn new skills and shares findings with others
	• Demonstrates self-directed staff and skill development
	• Supports the EDS values system, equal employment opportunity and sexual harassment policies, and dress code

Long Term Care Review Analyst/Auditor Job Description

Develop an understanding of the complete audit process. Work as a team member to develop the audit schedule and compile LTC reviews of IHCP-certified nursing facilities. Verify all elements of the audit are complete and within time frame. Generate weekly expense reports. Report problems or concerns to the office verbally or via memorandum. Maintain awareness of ongoing changes within EDS, the IHCP, and the provider community. Understand internal and external resources, such as Indiana*AIM*, EDSNet®, and state and federal regulations.

Long Term Care Review Analyst/Auditor Qualifications

- Registered nurse licensed to practice in Indiana or Licensed Social Worker (LSW) issued by Indiana
- Three years experience in a medical environment, long term care preferred
- QMRP or QMRP-D preferred
- Ability to complete day and overnight travel as required

Job Specific Skills and Essential Functions

Communication

- Communicates goals, assignments, audits, and expectations in a concise, organized, and effective manner; both orally and in writing
- Interacts with LTC providers, team members, the OMPP, and internal EDS departments

Customer Skills

- Develops and maintains an awareness of customer requirements and expectations
- Maintains knowledge of complete audit process
- Aware of ongoing changes in the IHCP regarding LTC as well as changes in priorities and the impact on the provider community
- Disseminates new information to providers
- Maintains positive working relationships with both the provider community and the OMPP
- Maintains familiarity with federal and state regulations and how to access them
- Identifies problem areas, offers solutions, and educates providers
- Demonstrates excellent communication and strong customer service commitment

- Identifies overall concerns during the audit process and follows up on identified situations or refers to management appropriately
- Offers suggestions or ideas to streamline or improve internal processes and procedures

Flexibility/ Adaptability

- Works effectively with all team members
- Comprehends and implements customer changes promptly
- Prepares schedules to meet the audit requirements, minimize costs, and meet team member needs
- Incorporates schedule changes with minimal disruption
- Accepts additional responsibilities in the office
- Offers alternative solutions

Business Skills

- Prepares accurate and timely expense reports
- Identifies areas for internal cost reduction
- Submits referrals for possible abuse or fraud situations
- Maintains knowledge of internal resources and responsibilities
- Maintains basic knowledge of Indiana*AIM*, EDSNET, and basic computer skills
- Demonstrates organizational ability in work, regardless of circumstances
- Anticipates schedule problems and avoids if possible
- Maintains high quality in balance with quantity
- Maintains professional demeanor at all times

Teamwork

- Interacts successfully with all teams members to accomplish LTC review
- Contributes actively to all phases of LTC work flow as needed
- Respects and listens to co-workers and shares information and concerns
- Develops a working relationship by respecting personal differences

Leadership

- Takes ownership of own work and team's work
- Displays initiative by willingly taking on additional assignments
- Volunteers for opportunities to learn new skills and shares findings with others
- Demonstrates self-directed staff and skill development

- Supports the EDS values system, equal employment opportunity and sexual harassment policies, and dress code

Long Term Care Hearing and Appeal Analyst Job Description

Develop an understanding of the complete audit process. Work as a team member to develop the audit schedule and compile LTC reviews of IHCP-certified nursing facilities. Verify all elements of the audit are complete and turned in within the given time frame. Generate weekly expense reports. Report problems or concerns to the office via memorandum or verbally. Maintain awareness of ongoing changes within EDS, the IHCP, and the provider community. Understand internal and external resources, such as Indiana*AIM*, EDSNET, and state and federal regulations.

Long Term Care Hearing and Appeal Analyst Qualifications

- Registered nurse licensed to practice in Indiana
- Three years experience in a medical environment
- Strong psycho-social assessment skills
- Long term care experience preferred
- QMRP qualifications preferred
- Ability to complete day and overnight travel as required

Job Specific Skills and Essential Functions

Communication

- Communicates goals, assignments, audits, and expectations in a concise, organized, and effective manner; both orally and in writing
- Interacts with providers—from initial phone call to exit conference—as well as team members and internal EDS departments

Customer Skills

- Develops and maintains an awareness of customer requirements and expectations
- Maintains knowledge of complete audit process
- Aware of ongoing changes in the IHCP as well as changes in priorities and the impact on the provider community
- Disseminates new information to providers
- Maintains positive working relationships with both the provider community and the OMPP

	• Maintains familiarity with federal and state regulations and how to access them
	• Identifies problem areas, offers solutions, and educates providers
	• Identifies overall concerns during the audit process and/or hearing and appeal process and follows up on identified situations or refers to management appropriately
	• Offers suggestions or ideas to streamline or improve internal processes and procedures
Flexibility/ Adaptability	• Works effectively with all team members
	• Comprehends and implements customer changes promptly
	• Prepares schedules to meet the audit requirements, minimize costs, and meet team member needs
	• Incorporates schedule changes with minimal disruption
	• Accepts additional responsibilities in the office
	• Offers alternative solutions
Business Skills	• Prepares accurate and timely expense reports
	• Identifies areas for internal cost reduction
	• Submits referrals for possible abuse or fraud situations
	• Maintains knowledge of internal resources and responsibilities
	• Maintains basic knowledge of Indiana*AIM* and basic computer skills
	• Demonstrates organizational ability in work, regardless of circumstances
	• Anticipates schedule problems and avoids if possible
	• Maintains high quality in balance with quantity
	• Maintains professional demeanor at all times
Teamwork	• Interacts successfully with all teams members to accomplish LTC review
	• Contributes actively to all phases of LTC work flow as needed
	• Respects and listens to co-workers and shares information and concerns
	• Develops a working relationship by respecting personal differences
Leadership	• Takes ownership of own work and team's work
	• Displays initiative by willingly taking on additional assignments

- Volunteers for opportunities to learn new skills and shares findings with others
- Demonstrates self-directed staff and skill development
- Supports the EDS values system, equal employment opportunity and sexual harassment policies, and dress code

Long Term Care Review Unit Office Coordinator Job Description

Works as a team member to prepare and mail all written correspondence.

Long Term Care Review Unit Office Coordinator Qualifications

- Minimum of a high school diploma
- Working knowledge of Microsoft Excel and Word programs

Job Specific Skills/Essential Functions

Communication

- Communicates goals, assignments and audits and expectations in a concise, organized, and effective manner both orally and in writing
- Interacts with providers as well as team members and internal EDS departments

Customer Skills

- Develops and maintains an awareness of customer requirements and expectations
- Maintains knowledge of complete audit process
- Maintains awareness of ongoing changes in the IHCP, changes in priorities, and the impact of the changes to providers
- Disseminates new information to providers
- Demonstrates strong customer service commitment (to providers and the OMPP)
- Maintains familiarity with federal and state regulations and how to access them
- Identifies problem areas, offers solutions, and educates providers
- Identifies overall concerns regarding the audit process and follows up or refers them to management as appropriate
- Offers suggestions or ideas to streamline or improve internal processes and procedures

Flexibility and Adaptability	• Works effectively with all team members • Understands and implements timely customer changes • Prepares schedules to meet audit requirements, minimize costs, and meet team member needs • Incorporates schedule changes with minimal disruption • Accepts additional responsibilities in the office • Offers alternative solutions
Business Skills	• Prepares accurate and timely expense reports • Identifies areas for internal cost reduction • Submits referrals for possible abuse or fraud situations • Knows internal resources and responsibilities • Knows basics of Indiana*AIM* and basic computer skills • Demonstrates organizational ability in work, regardless of circumstances • Anticipates schedule problems and avoids if possible • Maintains high quality in balance with quantity • Maintains professional demeanor at all times
Teamwork	• Interacts successfully with all teams members to accomplish LTC review • Contributes actively to all phases of LTC work flow as needed • Respects and listens to co-workers and shares information and concerns • Develops a working relationship by respecting personal differences
Leadership	• Takes ownership of own work and team's work • Displays initiative by willingly taking on additional assignments as needed • Volunteers for opportunities to learn new skills and share findings with others • Demonstrates self-directed staff and skills development • Supports the EDS values system, equal employment opportunity, and sexual harassment policies, and dress code

Long Term Care Review Unit Supervisor Job Description

- Provides oversight in LTC review functions

- Coordinates on-site reviews of all IHCP certified nursing facilities, as outlined in the contractual requirements

Long Term Care Review Unit Supervisor Qualifications

- Three years previous management experience
- Four years healthcare experience, preferably in long-term care
- Registered nurse, licensed to practice in the state of Indiana
- Medicare or Medicaid experience strongly preferred

Job Specific Skills/Essential Functions

Communication
- Possesses excellent verbal and written communication skills
- Experience in writing objectives, tasks, assignments, and expectations concisely
- Oversees the orientation and mentoring of new team members to EDS policies and job responsibilities
- Develops and disseminates information to team, either verbally or in writing, promptly and systematically

Customer Skills
- Develops and maintains an awareness of customer requirements and expectations
- Maintains and updates knowledge of any medical and program policy changes that affect the LTC Unit review activities
- Acts as a liaison to the long-term care provider community
- Maintains and updates knowledge of state and federal regulations, and the impact on long-term care
- Identifies problem areas, offers solutions, and educates providers
- Demonstrates a commitment to excellent customer service

Flexibility/ Adaptability
- Works effectively with LTC and other team members
- Understands and implements customer changes promptly
- Develops, prioritizes, and maintains work assignment schedule

Business Skills
- Understands the role and policy development of LTC review in the IHCP
- Oversees the completion of all federal and contractual requirements
- Identifies areas for internal cost reduction
- Uses EDSNet® systems, such as CAS, for all administrative functions

- Develops and maintains the salary plan for the LTC unit
- Maintains high quality in balance with increased quantity
- Develops schedules for on-site audits and other LTC review activity
- Reviews all documentation before submission to the customer
- Oversees the completion and approval of all monthly and quarterly reports for the customer

Teamwork

- Facilitates successful interaction among and between LTC and other team members to accomplish the Strategic Business Unit, Indiana Title XIX account, and LTC Unit goals
- Respects and listens to team members and co-workers, and provides information and guidance as needed

Leadership

- Takes ownership in own work and team's work
- Conducts job performance reviews with team members in accordance with the EDS prescribed schedule
- Supports the EDS value system, equal employment opportunity, sexual harassment, violence in the workplace, open door, and dress code policies in place on the account

Section 2: Work Flow Procedures

Introduction

This section includes the description for auditing a facility, from pre-audit through post-audit activities. This process is primarily directed to the EDS auditor; however, the roles and responsibilities of those contractors that interface with the auditing process are also addressed. This process reviews the certification of a new facility, audit scheduling, the audit process, and subsequent post-audit activities.

Each Case Mix audit review team shall be composed of no less than one registered nurse (RN) who acts as team leader and one additional staff member. The additional staff member may be a licensed social worker or registered nurse (RN). At least one member of the team shall be a Qualified Mental Retardation Professional (QMPR) or designee (QMPR-D), as defined under **42 CFR 483.430**.

Figure 2.1 provides a general overview of the Long Term Care (LTC) audit process.

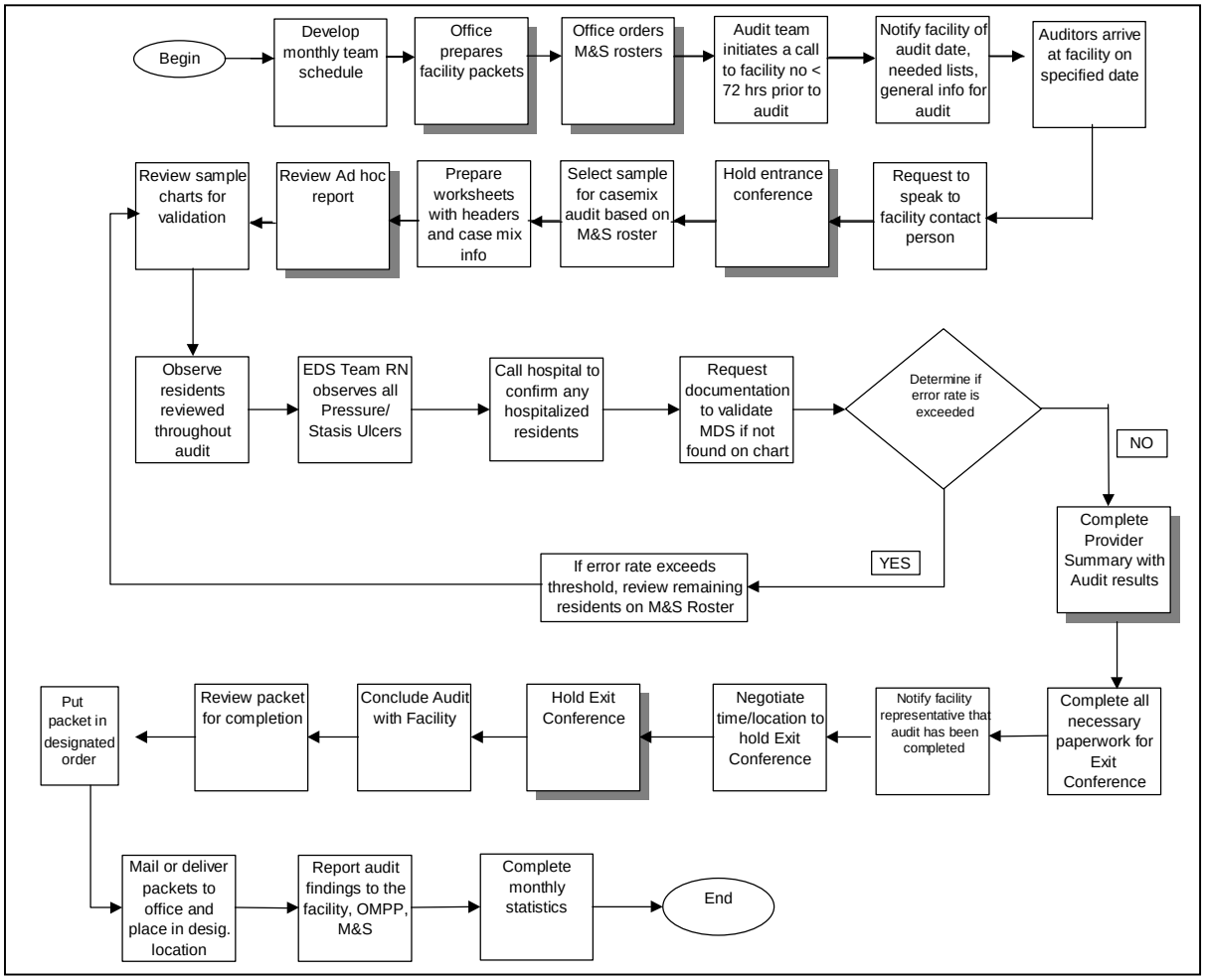


Figure 2.1 – Long Term Care Audit Process

Long Term Care Facilities

Scheduling of a New Long Term Care Facility

When the Indiana State Department of Health (ISDH) certifies a new facility, a copy of the certification letter is forwarded from EDS Provider Enrollment to the EDS LTC Unit. On receipt of the certification letter, the following procedures begin:

- The new facility is reviewed within 15 months of the certification date.
- The facility's name, address, provider number, and certification date are placed on the master file and in the Quarterly Report.

- The newly certified facility is added to the monthly schedule within the appropriate time frame.
- The copy of the certification letter will be maintained in the EDS LTC Unit.

Termination or Voluntary Withdrawal of a Facility

The Office of Medicaid Policy and Planning (OMPP), or the ISDH in coordination with the OMPP, can recommend termination of a facility from the IHCP. Regardless of which agency initiates termination action, the facility has the right to an appeal. If an appeal is initiated by the facility and an on-site audit is scheduled, the audit will be completed. No change is made in the audit schedule or Quarterly Report unless EDS has an official notification letter from the OMPP with the effective date of termination.

A facility may also initiate a voluntary withdrawal from the IHCP. No change is made in the audit schedule or Quarterly Report until the OMPP notification has been received.

Removal of Decertified Facility from Schedule

EDS receives the decertification or termination letter from the OMPP identifying the decertified or terminated facility. A decertification or termination letter is placed in the facility file, and the following information is recorded on the Quarterly Report:

- Effective date of the decertification/termination
- Notification for the audit team of the final decertification status and date
- Retaining of the decertified or terminated facility on the report until the quarter following 15 months from the date of the decertification or termination
- Notification of the date the decertification or termination was received by EDS

General Scheduling

Each facility is reviewed at least once every 15 months. Any audit that was not performed as scheduled is placed in the *audit pool* (the audit pool includes those facilities scheduled, but not audited). Those facilities are placed on a list to be prioritized on the next month's schedule until the audit is completed (within 15 months of the last on-

site review). More frequent visits are scheduled when the initial review indicates significant areas of concern. More information about scheduling can be found in the subsection entitled *Re-Audit Procedure* in this section. Figure 2.2 outlines the process.

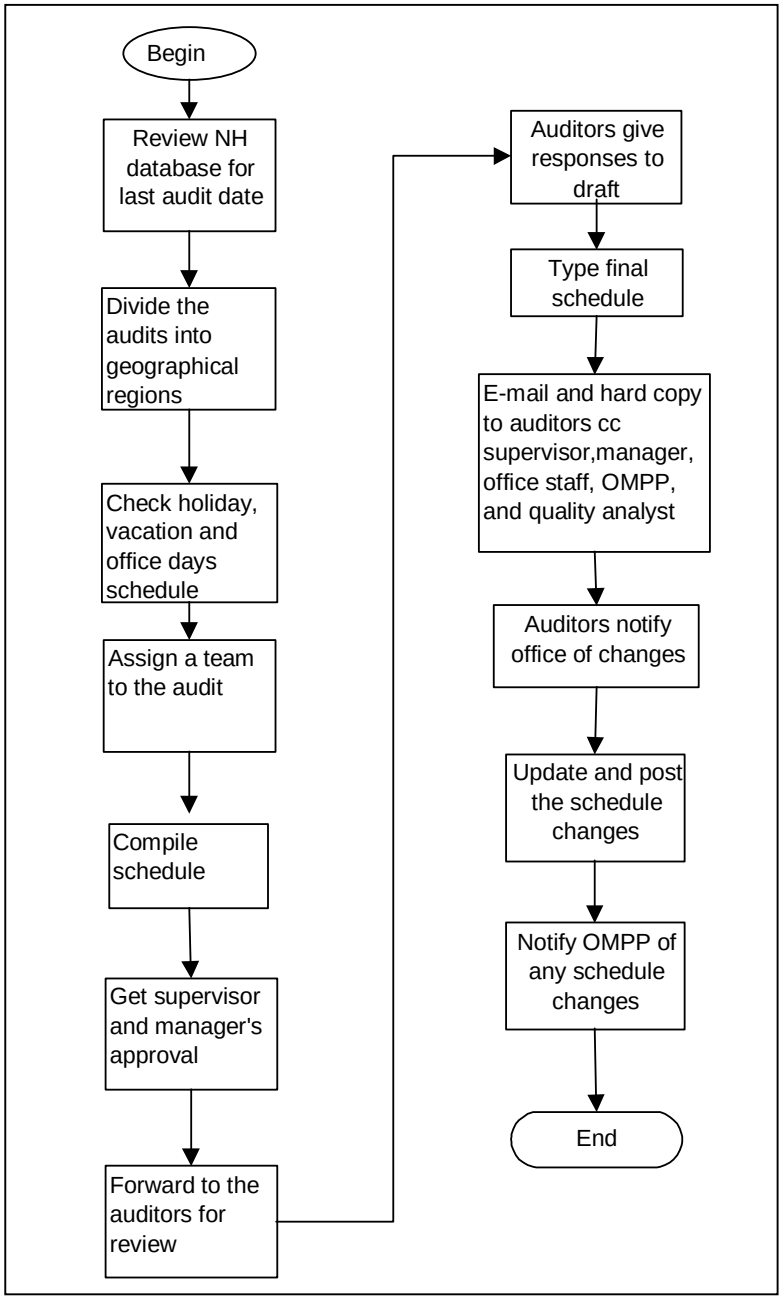


Figure 2.2 – Scheduling Work Flow

Pre-Audit Preparation

The EDS LTC office coordinator is responsible for obtaining information that facilitates audit performance. This includes the following reports:

- Ad hoc Report—This report depicts paid claims per recipient or per provider within a defined period (currently the two quarters preceding the quarter in which the audit is scheduled). The EDS Systems Unit generates this report.
- Resident roster, time weighted report for each facility—This report contains the most recently transmitted Minimum Data Set (MDS) assessment and RUG-III (Resource Utilization Group, Version 3) classification for each resident. Myers & Stauffer generates this report.
- Resident Audit Worksheets—These are generated by Myers & Stauffer and used by the audit team to record the audit findings.

This information is compiled into a facility-specific audit packet that includes both the Medicaid Audit Information (MAI) and the Mentally Ill/Mentally Retarded/Developmentally Disabled (MI/MR/DD) resident list from the last on-site review. Contents should also include the following:

- Blank memo to LTC supervisor
- Nursing Facility Postreview checklist
- Time Study form
- Attachment Tally sheet
- Provider Summary
- Blank Medicaid Audit Information (MAI) form
- End of Therapy list
- MI Statistics sheet
- Exit Conference sheet
- Entrance Conference form
- Blank audit worksheet
- Phone Contact sheet

This audit packet is distributed to the audit team the last week of the month preceding the audit. The resident roster is updated weekly by Myers & Stauffer on request from the EDS LTC unit.

Audit Packet Assembly

The EDS LTC Unit office coordinator or the audit team labels file folders with facility name, address, phone number or numbers, and provider number. The audit team uses all items in the audit packet throughout each audit. All packets must contain the following items:

- MI/MR/DD list from previous audit, located in the facility file cabinet
- *MAI* form from previous audit, located in the facility file cabinet
- One copy of all of the following forms:
  - Nursing Facility Postreview Check List
  - (Blank) *MAI* form
  - Referral form
  - Memorandum (Blank)
  - Nursing Facility Level-of-care/Additional Documentation
  - Nursing Facility Exit Conference for EDS Audit Team
  - Nursing Facility Audit Information (MI Statistics sheet)
  - Nursing Facility Entrance Conference for EDS Audit Teams
  - Phone Contact sheet
  - Traumatic Brain Injury Residents form
- Ad hoc Report (ordered quarterly through the EDS Systems Unit via e-mail)
- Roster (ordered weekly through Myers & Stauffer via computer modem)
- Nursing Facility Audit worksheets

Facility Notification

The auditor records the facility provider name, provider number, and facility phone number on the *Facility Notification sheet* provided in the packet. Also, the date and time the facility was contacted and the scheduled date of the audit is recorded.

The auditor telephones the facility no more than 72 hours prior to the scheduled audit. If a holiday falls within the 72-hour period, the auditor notifies the facility on the last working day before the holiday. The facility notification process follows the steps outlined in the following text:

1. The auditor who makes the phone call identifies him or herself to the facility staff and explains the purpose of the call.

2. The auditor asks to speak to the administrator or director of nursing. If neither is available, the auditor asks to speak to the Minimum Data Set (MDS) coordinator or the person in charge.
3. The auditor informs the facility representative of the audit date and approximate time of arrival.
4. The auditor records the name and title of the facility representative to whom the auditor spoke.
5. The auditor provides the facility representative with an overview of the audit process and expectations.

Example of an Overview

The purpose of the EDS LTC review is to verify that the IHCP is paying appropriately for necessary nursing home care services. During the audit, the audit team will examine the MDS in depth and validate responses with supporting documentation contained in the medical record. The MDS and supporting documentation on which the audit team will focus includes, at a minimum, the recent MDS transmissions and may include up to 15 months of data. The team will examine each resident's record to validate the assigned RUG-III classification. If documentation supporting the MDS responses is maintained separately from the active medical record, that material must be provided to the audit team. These items may include, but are not limited to, behavior logs and care plans, skin care sheets, decubitus records, weight records, therapy minute logs, and restorative nursing minute logs.

The EDS audit team will conduct an entrance conference on arrival at the facility and will present preliminary findings at an exit conference at the end of the on-site review.

The audit team will need the following information prepared by the time they arrive:

- An alphabetical listing of **all** facility residents (regardless of payer type), including each resident's first and last name, date of birth, date of admission, payer source, and identifying number (such as RID number or Social Security number).
- An alphabetical listing of **all** facility residents (regardless of payer type), who have an MI, MR, MR/DD, or MI/MR/DD diagnosis that has been confirmed by a Pre-Admission Screening and Resident Review (PASRR) Level II assessment.

- A listing of all residents with a Stage III or IV decubitus ulcer. This information may be noted next to the resident's name on the appropriate list previously described.

Additionally, a staff liaison must be identified and made available to the EDS audit team throughout the course of the audit.

After the overview to the facility representative, the auditor requests and records directions to the facility and encourages the provider to contact the EDS LTC Unit at (317) 488-5099 should questions arise before the audit.

For additional information, refer to *Section 6, Facility Notification Form*.

Facility Review – No Indiana Health Coverage Programs Residents

This section addresses the certified IHCP nursing facilities that do not have an active Indiana*AIM* provider number. These facilities have no IHCP residents but may have a resident with an MI/MR/DD diagnosis that has been confirmed by a Level II assessment.

Facilities identified as not having any MI/MR/DD or IHCP residents are contacted quarterly to confirm their status. If no change is noted, they remain a quarterly contact.

Should the facility confirm an MI/MR/DD or IHCP resident, an audit visit is scheduled within 30 days. These audits are conducted as described in the section *Level-of-care Review*. The audit team should use the Level of Care/PASRR worksheet.

When the audit is complete, the facility is scheduled for review within the next 15 months.

Official Quarantine in a Facility

The facility may give notice of an official quarantine at the time an audit notification phone call is made or when the EDS LTC audit team arrives at the facility for the audit. When this occurs, the audit team takes the following steps:

1. The audit team requests a letter from the facility's medical director or the ISDH stating that the facility is under an official quarantine and gives a time estimate for the quarantine. (This may be mailed to the LTC supervisor at EDS within 15 days.)
2. The audit team notifies the EDS LTC supervisor of the quarantine and that the review must be rescheduled. The facility should send a

follow-up letter and a copy of the letter from the medical director or ISDH confirming the official quarantine to the EDS LTC supervisor.

3. The audit team notifies the OMPP by telephone and sends a follow-up letter stating that the facility is under quarantine and the audit will not be completed as scheduled.
4. The audit team places a copy of the letter from the medical director or the ISDH in the facility file and notes the placement in the Quarterly Report.
5. The facility name is placed in the *audit pool* and is telephoned monthly to confirm status of quarantine.
6. When the quarantine is removed, the facility is audited within 30 days.

When these steps are taken, the audit team prepares to audit the next LTC facility on the schedule.

Entrance Procedures

Entrance Conference

On arrival at the facility, the audit team introduces themselves and presents their business cards to the facility liaison. The team explains the purpose of the visit and invites the liaison to assemble the staff for the entrance conference. During the entrance conference, the audit team performs the following tasks:

- Records the names of the administrator and director of nursing.
- Advises the administrator or liaison that any residents scheduled to be leaving the facility before the completion of the medical records review should be identified so the team can make other arrangements for resident observation.
- Informs the staff that the EDS registered nurse needs to observe all Stage III or IV decubitus ulcers of residents whose names appear on the resident roster
- Verifies the facility's current provider number, name and address, and informs the liaison that the audit will be conducted under the name listed on the Quarterly Report unless notification of the change has been received by EDS
- Obtains the phone numbers of hospitals as needed to verify the hospitalization of any IHCP resident or IHCP pending resident hospitalized during the audit
- Reviews the organization of medical records with the director of nursing or designee. Reviews the content of the entire medical

record, overall care plan, and so forth, with the liaison and resolves questions regarding the type of documentation or the location of the documentation in the medical record

- Obtains the lists of residents requested by the auditor in the facility notification telephone call.

In concluding the Entrance Conference, the audit team identifies the facility appointed staff liaison that will be available to assist the auditors throughout the review process. The staff liaison should sign the entrance conference form where indicated.

Recipient List From Facility

1. Request the alphabetical listing of all facility residents regardless of payer type. Check the list for the recipient's full name, date of admission, date of birth, and identifying number of current payer source. The identifying number is the Recipient Identification number (RID), for IHCP recipients and the Social Security number for all other residents. For residents pending IHCP approval, use the resident's Social Security number and write the word **pending** on the audit worksheet. Cross-reference this list with the facility's resident roster.
2. If any information is missing, the facility liaison takes the list to the appropriate person to complete, and the list will be rechecked on return.
3. Write the provider name, address, and provider number at the top of each page of the list. A facility name and address stamp is acceptable, with the provider number added.
4. Total the number of residents on the list to ensure that number equals the current census. Admissions or discharges during the audit, are added or crossed out as needed, and the list is compared to the current census again. Discrepancies in the totals must be reconciled before continuing. Check for duplicate listings of patient names. Check the Ad hoc Report against the names of IHCP residents on the list. Ask the liaison to take the list to the appropriate person to resolve any problems. Verify that the list includes hospitalized residents (within the 15-day bed-hold time frame). The audit team must also verify that the list does not include the names of residents who have been discharged from the facility. The list must be a complete and accurate record of all residents in the building as well as all IHCP bed-hold residents.
5. Place an EDS audit label on the last page of the resident list. The administrator or designee must sign this at the exit conference.

Selection of Review Sample

The audit team is responsible for reviewing medical records for a sample of the resident population in the facility. For a regularly scheduled case mix audit, the selection criteria is as follows:

- Sample selection for a case mix audit is based on the resident roster.
- A minimum of 40 percent of residents or 25 residents, whichever is greater and regardless of payer source, are initially selected for the review sample. The sample size represents the proportion of IHCP to non-IHCP residents as reported on the resident roster, whenever possible.
- Rehabilitation, Extensive Services, and Special Care audits include 100 percent of the residents.

Indiana Office of Medicaid Policy and Planning

Provider: 00000000 FACILITY NAME
For the quarter 06/12/00 to 09/12/00. Includes records received through 09/12/00.

Resident Name	SSN	Medicaid	Record Type/ Assessment Reason(s)	RUG Code	Indiana Key Date		HCFA Effective Date		Days	Payor Source	Hospice
					Date	Date Field	Date	Date Field			
SPECIAL REHABILITATION											
Resident #1	111-11-1111	N	*Q/05/*	*RHC*	*8/8/00*	*A3a*	*8/8/00*	*R2b*	*35*	*Other*	*N*
ADL: 14 G1aA(3), G1aB (2), G1bA(3), G1bB(2), G1iA(3), G1iB(2), G1hA(2) - 340 total minutes of therapy - P1bbA(5), P1bbB(0205), P1bcA(3), P1bcB(0135)											
CLINCALLY COMPLEX											
Resident #2	444-44-4444	100444444499	*Y/03/*	*CB2*	*8/10/00*	*A3a*	*8/10/00*	*R2b*	*33*	*Medicaid*	*N*
ADL: 8 G1aA(0), G1aB (0), G1bA(2), G1bB(2), G1iA(2), G1iB(2), G1hA(1) - Clinically Complex condition(s): I1r(1) - Depression indicated by: I1ee(1), E1n(1), K3a(1)											
IMPAIRED COGNITION											
Resident #3	555-55-5555	N	*OM/00/8*	*IA2*	*8/12/00*	*A3a*	*8/12/00*	*R2b*	*30*	*Medicare*	*N*
ADL: 4 G1aA(0), G1aB(1), G1bA(0), G1bB(1), G1iA(0), G1iB(1), G1hA(0) - NRS: 2 - Impaired Cognition condition(s): B2a(1), B3a(0), B3b(0), B3d(0), B4(2) - Nursing Rehab Types: P3a(5), H3a(1)											
REDUCED PHYSICIAL											
Resident #4	333-33-3333	100333333399	*Y/03/*	*PD2*	*7/5/00*	*A3a*	*7/5/00*	*R2b*	*70*	*Medicaid*	*N*
ADL: 11 G1aA(2), G1aB(2), G1bA(2), G1bB(2), G1iA(2), G1iB(2), G1hA(2) - NRS: 2 - Nursing Rehab Types: P3a(7), P3b(7)											

Figure 2.3 – Example of Resident Roster

The initial review sample should include the following:

- Rehabilitation, Extensive Services, Special Care – 100 percent of residents
- Clinically Complex – At least 10 residents, or 100 percent if less than 10 residents
- Impaired Cognition, Behavior Problems, Reduced Physical Function – In each RUG-III category, a minimum of five residents, or 100 percent if less than five residents

When the sample selection detailed previously is less than 40 percent of the facility census, the audit team reviews the resident roster and selects additional residents for review. Additional residents could be selected to fulfill the EDS or the Pre-admission Screening and Resident Review (PASRR) audit requirements. Residents may also be selected based on unusual trending of RUG-III combinations indicating that a significant change assessment was warranted but not initiated by the facility. Trends regarding reimbursement issues are also noted.

The audit protocol indicates that the audit team reviews the most current, transmitted assessment for a resident but allows for review of more than one assessment at the auditor's discretion.

When determining sample size and selection for PASRR review, the following applies:

- PASRR – 25 percent of the confirmed MI/MR/DD diagnosed residents, with a minimum of five residents or 100 percent if less than five residents.

Table 2.1, outlines the sample and selection criteria. This table illustrates the number or percentage of residents for review. These review sample guidelines are followed for regularly scheduled facility audits and may be expanded to include more residents.

Table 2.1 – Sample and Selection Criteria for Facility Review

Category of Resident Review	Payer Source	Number or Percentage to Review
PASRR Review	All residents in the IHCP are subject to PASRR review	25 percent confirmed MI/MR/DD diagnosed residents—minimum of five residents
Institutions for Mental Disease (IMD) Identification	IHCP residents	100 percent IHCP residents with a confirmed MI diagnosis on their most current Level II assessment
Case Mix Review	All residents—equal proportion of IHCP to non-IHCP residents (where possible)	Minimum of 40 percent or 25 residents, whichever is greater
Rehabilitation		100 percent of residents in this RUG-III category
Extensive Services		100 percent of residents in this RUG-III category
Special Care		100 percent of residents in this RUG-III category
Clinically Complex		Minimum of 10 residents, or 100 percent if < 10 in this RUG-III category
Impaired Cognition		Minimum of five residents, or 100 percent if < 5 in this RUG-III category
Behavior Problems		Minimum of five residents, or 100 percent if < 5 in this RUG-III category
Reduced Physical Function		Minimum of five residents, or 100 percent if < 5 in this RUG-III category
Level-of-care Review	All IHCP and IHCP-pending residents	
In conjunction with the Case Mix Review		All residents reviewed during Case Mix Review
Not in conjunction with Case Mix Review (NFs not subject to Case Mix Reimbursement)		100 percent designated skilled level IHCP residents, and 25 or 25 percent (whichever is greater) of designated intermediate level IHCP residents

At the conclusion of the initial sample review, the audit team determines if the audit needs to be expanded to include 100 percent of the residents. If the percentage of erred records exceeds the error threshold, set forth in *405 IAC 1-14.6* of the initial sample, the review expands to include 100 percent of the residents. See the subsection titled *Exit Conference* in this section for details.

Ad hoc Report Completion

The Ad hoc Report enables the audit team to compare paid claims information to the current list of recipients in a facility and record information about residents that are not currently IHCP recipients.

REPORT: PRV-0001-Q — Indiana AIM — Run Date: 00/00/0000
PROGRESS: PRVJQ001 — QUARTERLY IOC FACILITY/RECIPIENT REPORT — RUN TIME: 11:06:36.5
LOCATION: PRV0001Q — QUARTER ENDING: 00/0000 — PAGE: 240
DOS: 01/0000 - 03/0000

PROVIDER NAME	PROVIDER NUMBER	LOC	RECIPIENT NAME			RID	DATE OF BIRTH	DATE OF ADMISSION
AUDITORS REST HOME	111222333	651	BERG	LORI	Q	111111111111	19000101	20000331
			ELSBURG	MURRAY	J	222222222222	19220202	20000401
			KOELLER	LYRA	B	333333333333	19330303	20010202
			NOTARE	CARL	F	444444444444	19520404	20001010
			ROSEN	ANDY	P	555555555555	19410505	20001212
			SLIPES	DIANE	A	666666666666	19220606	20000405
			THURSTY	TERRI	W	777777777777	19300707	20010514

NUMBER OF RECIPIENTS IN THIS FACILITY: 7

Figure 2.4 – Example of Ad hoc Report

The audit team's first obligation is to compare the Ad hoc Report to the facility list. One team member reads aloud the names of the IHCP recipients from the list provided by the facility. A second team member indicates that the recipient is an active resident of the facility by placing a checkmark on the left side of the Ad hoc Report next to the name of the resident.

If names of IHCP recipients on the facility list are not on the Ad hoc Report, those names and corresponding RID numbers are added to the Ad hoc Report. The auditor writes these names on the Ad hoc Report, in alphabetical order when possible. The names of IHCP-pending residents are added to the bottom of the Ad hoc Report, and the auditor writes **pending** next to the resident's name.

Next, one of the audit team members double-checks the number of IHCP and IHCP-pending residents to ensure the lists are the same. An audit team member counts the number of names, and writes the number at the bottom of both the Ad hoc Report and the facility list and initials both. This information is recorded in the following manner:

Number of IHCP residents+Number of IHCP pending residents=Total

For example, a facility with 50 IHCP residents and 7 IHCP-pending residents would have the following equation recorded on the document: *50 + 7 pending = 57 total*. The auditor writes his or her initials next to the total and date.

Resolution of the Ad hoc Report is performed using IHCP discharge information supplied by a staff member of the facility. One member of the audit team circles the names of all residents whose names appear on the Ad hoc Report but who are not currently IHCP facility residents. The audit team requests that the facility bookkeeper make a copy of the Ad hoc Report and instructs the bookkeeper to record the following information on the copy next to each circled name:

- The last date of service (includes up to 15 days of bed-hold if the resident is hospitalized)
- The disposition of the resident, such as discharged to home, discharged to another facility, discharged to hospital, deceased (RHC or expired), or changed to another payer source

At the end of the medical record review, the auditors must record the following information in red ink on the Ad hoc Report next to the names of the residents included in the audit sample:

Table 2.2 – End of Medical Review Information

Auditor's Recording	Description
NF	A completed *Form 450B* or *450B SA/DE* was present on the resident's chart, and the resident continues to meet the minimum level of service for facility level-of-care.
Res. Seen/No 450B	*Form 450B* or *450B SA/DE* was not found on the chart
In Process	*Form 450B* or *450B SA/DE* has been sent to the OMPP but not yet approved for IHCP reimbursement

(Continued)

Table 2.2 – End of Medical Review Information

Auditor's Recording	Description
Pdg	Written next to the name of an IHCP-pending resident included in the audit sample
R	Written next to the name of all residents recommended for a Level II referral
D/C	Written next to the name of any resident that is not found to require facility level-of-care.
D/C-R	Written next to the name of any resident with an MI/MR/DD diagnosis and an approved 450B or 450B SA/DE who does not appear to meet the facility level-of-care.

*Note: **D/C** and **D/C-R** recommendations apply only for residents for whom the facility has an approved Form 450B or Form 450B SA/DE.*

When the bookkeeper returns the copy of the Ad hoc Report with the information requested by the team, one member of the audit team records the discharge date and disposition next to each circled name on the Ad hoc Report. The total number of circled names are counted and recorded at the bottom of the Ad hoc Report (for example, "8 resolved").

Ad hoc Report resolution is complete when the audit team has performed all activities listed previously and conducted a final count ensuring the number of residents on the facility list is equal to the number of residents listed on the Ad hoc Report. The audit team also confirms the appropriate audit information is recorded next to the name of each resident included in the review sample.

If no Ad hoc Report is available, auditors are to leave the **Resolve** space blank on the MAI and ask the facility for a list of all IHCP discharges—with dates and disposition—since the last audit.

Medical Record Review

PASRR Review

At the conclusion of the entrance conference, the auditors request the medical records for the MI/MR/DD residents whose names appear on

the list provided by the facility. To ensure that the list is accurate the audit team must confirm that Level II information has been completed for appropriate residents by reviewing Level II recommendations and ensuring that they are being provided. If the Level II determination does not verify the diagnosis of MI/MR/DD, the auditors note that information on the list. (This list must be accurate and must be certified by a facility representative at the exit conference.) The audit team is responsible for reviewing all residents on this list. The auditors should incorporate at least five records or 100 percent if less than five records, of MI/MR/DD residents into the Case Mix Review sample. If the names of these residents do not appear on the resident roster, the audit team completes the PASRR and IHCP level-of-care portion of the audit worksheet. This worksheet is outlined in the *Audit* worksheet *Completion* section of this manual.

Case Mix Reimbursement Review

405 IAC 1-15-4 requires the OMPP to publish supportive documentation guidelines for MDS data elements used to classify facility residents according to RUG-III resident classification system. The latest guidelines were published by the OMPP and distributed to nursing facilities in October 2000. These guidelines serve as the basis for the Case Mix Reimbursement portion of the facility audit. The audit team uses these *Supportive Documentation Guidelines*, in combination with the *Resident Assessment Instrument* (*RAI*) *Manual*, as they review the medical record for each resident.

405 IAC 1-15-4 (b) states: *Nursing facilities shall maintain supporting documentation in the resident's medical chart for all MDS data elements that are used to classify nursing facility residents in accordance with the RUG-III classification system. Such supportive documentation shall be maintained by the nursing facility for all residents in a manner that is accessible and conducive to audit.*

HCFA designed the *RAI Manual* as a comprehensive assessment tool, to be used by clinicians for direction in the design of individual care plans and programs for the residents they serve. The *RAI Manual* provides guidelines related to coding of the MDS, along with the *Supportive Documentation Guidelines*. The LTC review analyst uses the *RAI Manual* Version 2.0, published October 1995, as a reference for case mix on-site audits.

The EDS audit team considers all supportive documentation presented for review until the exit conference. The facility must be informed of documentation that is needed for the medical record review and must

be given the opportunity to provide the auditors with any documents that are not located on the resident's chart.

The EDS audit team is responsible for validating each MDS data element used to classify a resident using supportive documentation within the prescribed seven-day assessment period. To calculate the assessment period, the auditor starts with the A3a date, (assessment reference date), and counts back six days for a total of seven days. The RUG–III elements and documentation standards drive the medical record review. The audit team reviews the medical record for documentation to support the coded response. Review of the medical record documentation may reveal that the facility under coded the responses on the MDS. If the audit team discovers documentation supporting a data element not coded on the MDS, this information is recorded on the audit worksheet in the **Comment** section.

The *Supportive Documentation Guidelines* document, published by the OMPP in October 2000, is included in this manual. The section outlining formulas for determining the ADL score component of the RUG–III classification is included for reference only. Although each LTC auditor needs to understand how Myers & Stauffer calculate the ADL score, it is not the auditor's responsibility to determine what the actual ADL score is. The MDS responses are reconciled based on audit findings.

The *Supportive Documentation Guidelines* published by the OMPP lists all elements used to classify a resident in each of the 44 RUG classifications of the RUG–III category. Although there are 87 data elements on the *MDS* form that influence classification, not all elements influence every RUG–III category. The *Supportive Documentation Guidelines* for each RUG–III category address those specific MDS data elements that would cause an assessment to classify in that particular RUG–III group. The audit team should use the *Supportive Documentation Guidelines* to conduct the medical record review portion of the audit. The audit team must locate documentation in the medical record, within the assessment period defined on the MDS. This documentation must support the elements that caused the assessment to group to a particular RUG–III classification.

The MDS may have more than the minimum required elements for a particular RUG–III classification. In those cases, the audit team needs to validate the minimum number of elements in that category. Examples of this protocol are addressed in the narrative following the *Supportive Documentation Guidelines* for each RUG–III category.

The medical record portion of the audit is not complete until the audit team has recorded all audit recommendations on the Ad hoc Report.

This process is explained in the section entitled *Ad hoc Report Completion.*

Case Mix Audit Worksheet Completion

Case mix audit worksheets are preprinted with the following information:

- Facility name
- Provider number
- Resident name
- Social Security number
- RID number, if applicable
- Date of birth
- Start observation date
- A3a date
- Record type
- Trans RUG code
- Nsg restorative
- Trans ADL score

If a worksheet or worksheets for the audit packet must be made, the auditor is responsible for ensuring that the facility's name and provider number are accurately recorded on the worksheet and completing all other sections.

Provider Name
Provider Number

Inidana Office of Medicaid Policy and Planning
MDS Audit Worksheet

Audit Dates _____

Resident Name _____
SSN # _____
RID # _____
Birthdate_____ **Admission Date** _____
Diagnosis _____

Last Level II Date _____ **MH Assess**
MI/DD: Y N **Serv. Prov Y N**
DX: _____

Recommendation: _____

450B Date: _____ **IN PROC ABSENT N/A**
Meets NF Criteria Y N 1-3-1 405 IAC 1-3-2
Auditor _____|_____|_____ **Rev. Date** _____
Reviewing MD _____ **Rev. Date** _____
Agree Disagree

Record Type _____
Trans RUG Code _____
Start Observation Date _____ **AB1 date**
A3a Date _____
Nsg Restorative _____
Trans ADL Score _____
Audited ADL Score _____

ADL Score Unsupported? **YES NO**
Element Unsupported? **YES NO**
EOT Date _____
A3a date exceeds 10 days **YES NO**
SCSA Date _____
SCSA exceeds 14 days? **YES NO**
RUG Change? **YES NO**

# of Records Reviewed _____
# of Erred Records _____

D/C D/CR R

Ver. 0201

MDS ADL Fields

Item No.	Description	Transmitted Value	Documentation Supports Reported Value?	Audited Value	Comments
1	G1a.A Bed Mobility Self Perf		Yes ☐ No ☐		
2	G1a.B Bed Mobility Support		Yes ☐ No ☐		
3	G1b.A Transfer Self Perf		Yes ☐ No ☐		
4	G1b.B Transfer Support		Yes ☐ No ☐		
5	G1i.A Toilet Use Self Perf		Yes ☐ No ☐		
6	G1i.B Toilet Use Support		Yes ☐ No ☐		
7	G1h.A Eating Self Perf		Yes ☐ No ☐		
8			Yes ☐ No ☐		
9			Yes ☐ No ☐		
10			Yes ☐ No ☐		
11			Yes ☐ No ☐		
12			Yes ☐ No ☐		
13			Yes ☐ No ☐		
14			Yes ☐ No ☐		
15			Yes ☐ No ☐		
16			Yes ☐ No ☐		
17			Yes ☐ No ☐		
18			Yes ☐ No ☐		

Figure 2.5 – MDS Audit Worksheet

The following information is required for each audit worksheet:

- **Resident name and Social Security number**, as they appear on the resident roster, is recorded in the appropriate area of the worksheet. If there is a discrepancy between the name or number on the roster and the name or number on the medical record, Myers & Stauffer must be notified.
- **Resident identification (RID) number,** a 12-digit number, is recorded for those residents for whom the IHCP is **currently** the primary payer source.
- If the resident is pending IHCP, **pending** is written in the *RID number* space and in the *450B Date* space.
- **Resident birth and admission dates** are recorded in the appropriate areas.
- **Start Observation Date** is based on the A3a date less six days. This date is the beginning of the seven-day assessment period.
- **A3a Date** is from the most recently transmitted MDS assessment. This date is the last day of the assessment period.
- **Record Type** consists of a combination of alphabetic and numeric characters.
- **Trans RUG Code** consists of three alphabetical and/or numerical characters.
- **Nsg Restorative** refers to the number of nursing restorative elements found on the roster. If **0** is indicated on the roster, **0** is written in the appropriate space on the worksheet. If no number is listed for nursing restorative, a dash (–) is placed in the appropriate space on the worksheet.
- **Trans ADL Score** is the numeric score representing the ADL score transmitted with the MDS.
- **Transmitted Values** are numeric values transmitted by the facility, based on assessment period findings.
- **MDS RUG Fields Item No.** and **Description** are alphabetic or numeric elements that cause an assessment to group to a particular RUG–III classification when coded on the MDS.

Information found in the resident's medical record. This information is recorded on the right-hand side of the worksheet:

- The audit team indicates whether documentation in the medical record supports the reported value on the MDS by placing a checkmark in the appropriate box.

- When the documentation supports the transmitted value, the audit team places a checkmark in the *Yes* box for that element.
- When the document does not support the transmitted value, the audit team places a checkmark in the *No* box.
- If the audited value is different than the transmitted value, and the auditor is able to determine what the appropriate value should be, this information is recorded in the *Audited Value* column.
- For every *No* box checked, the auditor records in the *Comments* section the reason the documentation does not support the transmitted value. An example of this notation is "Nurses note on 3/1/00 conflicts with information coded on the MDS."

Information found in the resident's medical record. This information is recorded on the left-hand side of the worksheet:

- **Diagnosis**: The audit team records the resident's diagnosis in the appropriate location on the worksheet.

> *Note: Physicians' diagnoses must be dated within one year of the A3a date.*

- **Last Level II Date**: The audit team must record the most current Level II assessment date, diagnosis, and recommendations on the worksheet. The audit team indicates whether recommended services are being provided by circling **Y** or **N** as applicable.
- **450B Date**: This section is completed if the IHCP is the resident's primary payer. The date entered is the *effective date* found on the 450B.

> *Note: The 450B date must not be earlier than the date of admission to the facility.*

  - **IN PROC**: This item is circled if the 450B process has been initiated but not finalized. (The facility is awaiting an approved 450B from the OMPP.) The date the physician signed the 450B is recorded in the space provided on the worksheet for the 450B date. When the 450B SA/DE has been sent to the OMPP, the date sent can be recorded.
  - **ABSENT**: This term is circled if the resident has the IHCP as the primary payer, but the facility is unable to produce a completed 450B.
  - **N/A** (not applicable): This item is circled if the IHCP is not the resident's current payer.

- **Audited ADL Score**: These are the results found from documentation of ADLs during the seven-day assessment.
- **ADL Score Unsupported**: If the audited score differs from the transmitted score, the auditor circles **YES**. If the score remains the same, the auditor circles **NO**.
- **Element Unsupported**: If the audit reveals inadequate documentation to support the element's transmitted value the auditor circles **YES**. **NO** is circled when the audit reveals adequate supportive documentation for the element's transmitted value.
- **End of Therapy (EOT) Date**: This date represents the last day the resident received any type of therapy. If therapy has not ended at the time of the audit, **ongoing** is written in this space.
- **A3a date exceeds 10 days**: Per *405 IAC 1-15-6***,** "Nursing facilities shall complete and transmit a new full MDS assessment for all residents after the conclusion of all physical, speech and occupational therapies. Such new full assessments shall be completed in order that the MDS assessment reference date (A3a) shall be no earlier than eight (8) days, and no later than ten (10) days after the conclusion of all physical, speech and occupational therapies. If the resident expires or is discharged from the facility, no such new assessment is required." This requirement is effective April 1, 1999.
- **Significant Change Status Assessment (SCSA) Date**: A Significant Change in Status Assessment is completed by the facility when a resident experienced a consistent pattern of changes, with two or more areas of decline or improvement.
- **SCSA exceeds 14 days**: When a significant change in the status of a resident occurs, prompting an SCSA, the facility completes a comprehensive assessment not later than 14 days following the occurrence of significant change. If the SCSA is later than 14 days the auditor circles **YES**.
- **RUG Change**: If the audited ADL score or the audited element does not meet the criteria for that RUG classification, **YES** is circled. If the audit validates the MDS response for ADL or element, **NO** is circled.
- **# of Records Reviewed** and **# of Erred Records**: The audit team records the number of records reviewed and the number of records in error for this resident. When reviewing, an EOT or SCSA record counts as a second record. A record not completed as required counts as a record in error; although, the audit team did not review an actual assessment.

- **Auditor/Review Date:** The auditor initials the audit worksheet and indicates the review date. A second member of the audit team initials the worksheet after reviewing and confirming the record is erred.

ADLs

All facility ADL documentation must reflect all shifts during the seven-day assessment period. Refer to page 3-74 in the *RAI Manual* that discusses this process.

The MDS must be coded to reflect supportive documentation found throughout the medical record. Documentation variations are allowed in each area of the ADL self-performance. Refer to the specific definitions in the *RAI Manual*.

The ADL documentation may be presented in a variety of formats, such as narrative notes, grid, or spreadsheet. As long as the documentation captures all the information required by the *RAI Manual*, any of these forms or formats is acceptable.

> *Note: The EDS audit team cannot endorse or recommend any particular form or format.*

Every RUG–III category contains an ADL score made up of the following:

- Bed Mobility
- Transfer
- Toilet Use
- Eating

These scores include resident self-performance and staff support. The audit team looks for documentation, within the seven-day assessment, to support the numeric coding on the MDS. Table 2.3 and Table 2.4 provide scores and descriptions for these assessments.

Table 2.3 – ADL Self-Performance (Column **A** on the MDS)

Score	Description
0–Independent	No help or oversight, **or** help/oversight provided only one to two times during the last seven days.
1–Supervision	Oversight, encouragement, or cueing provided three or more times during the last seven days, **or** supervision (three or more times) **plus** physical assistance provided only one to two times during the last seven days.
2–Limited Assistance	Resident highly involved in activity; received physical help in guided maneuvering of limbs or other non-weight bearing assistance three or more times, **or** more help provided only one to two times during the last seven days.
3–Extensive Assistance	While the resident performed part of the activity over the last seven-day period, help of the following types was provided three or more times: • *Weight bearing support* • *Full staff performance during part (but not all) of the last seven days.*
4–Total Dependence	Full staff performance of this activity during entire seven-day period.
8–Activity Did Not Occur During Entire Seven-day Period	ADL activity itself did not occur during entire seven days.

Table 2.4 – ADL Support Provided (Column **B** on the MDS)

Score	Description
0–Independent	No setup or physical help from staff
1–Supervision	Setup help only
2–Limited Assistance	One-person physical assistance
3–Extensive Assistance	Two plus persons physical assistance
8–Activity did not occur during entire seven days	ADL activity itself did not occur during entire seven days.

The *RAI Manual* provides descriptions of each of these ADLs. For example, transfer on or off the toilet is included in toilet use, not transfer.

Each ADL score contains information regarding the nutritional consumption of the resident. This includes the administration of IV

and parenteral fluids or the presence of a G-tube. If the resident has a G-tube, IV access, or other parenteral fluid access, the auditor looks for supportive documentation for these elements and disregards the eating section of the ADLs. If neither is coded, the ADL score refers to the eating self-performance code in column **A** only.

When the documentation in the medical record does not support the response codes on the MDS for the four ADLs, the audit team assigns the appropriate value based on documentation available and page *3-80* of the *RAI manual*. Refer to the *RAI Manual* and the following subsection, *Supportive Documentation Guidelines* for more information.

Supportive Documentation Guidelines Related to RUG-III Version 5.01 IHCP

The ADL Score is a critical component of the classification process used in all determinations of a resident's placement in a RUG-III category. The following is an explanation of the process for ADL calculation:

1. To calculate the ADL score, use the following formula and Table 2.5 for bed mobility (G1a), transfer (G1b), and toilet use (G1i).

Formula

2. Compare the response in column A to the response in column B to arrive at the ADL score.

Table 2.5 – ADL Scoring

Column A	Column B	ADL Score
0 or 1	any number	1
2	any number	3
3 or 4	2	4
3, 4 or 8	3 or 8	5

3. To calculate the eating ADL score, first refer to K5a (parenteral/IV) and K5b (feeding tube). If either or both are checked, the eating ADL score is **3**. Total all four components of the ADL scores. If neither K5a nor K5b are checked, go to Step 4 to calculate the eating ADL score.
4. When neither K5a nor K5b are checked, refer to the response to G1hA, and score the eating ADL component based on the following chart

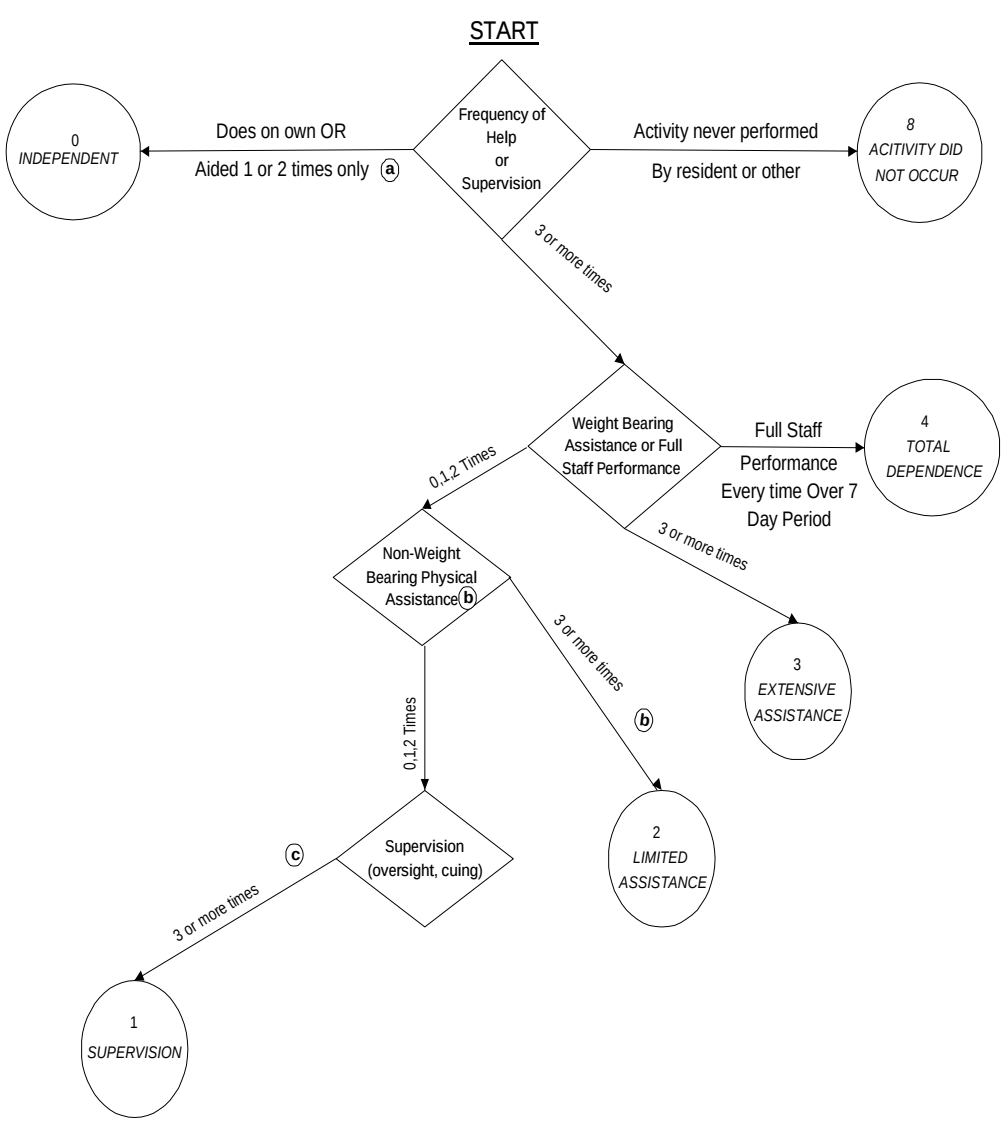
Formula

5. For the response in Column **A**, the ADL score is the corresponding number in the following chart:

Table 2.6 – ADL Scoring

Column A	ADL Score
0 or 1	1
2	2
3, 4 or 8	3

6. Now total the ADL score for bed mobility, transfer, toilet use, and eating.



a. Can include one or two events where received supervision, non-weight bearing help, or weight bearing help.

b. Can include one or two episodes of weight bearing help--e.g., two events with non-weight bearing plus two of weight bearing would be coded as a "2".

c. Can include one or two episodes where physical help received--e.g., two episodes of supervision, one of weight bearing, and one of non-weight bearing would be coded as a "1".

Figure 2.6 – ADL Tree

Special Rehabilitation

Table 2.7 – Special Rehabilitation

MDS 2.0 Version 5.01			
Special Rehabilitation			
MDS 2.0 Location	**Field Description**	**Charting Guidelines**	**Possible Chart Location**
G1a,b,i Col. A,B and G1h,A **ADL ONLY** (page 3-77, 3-78, 3-82)	Physical Functioning and Structural Problems ADLs	Four ADLs must be addressed in the medical chart for purposes of validating the MDS responses. These ADLs include bed mobility, transfer, toileting, and eating. Consider the resident's self-performance and support provided during all shifts, as functionality may vary.	NN, SSN, SN, CP, NR
K5a **ADL ONLY** (page 3-130)	Parenteral/IV	Evidence of an IV or heparin lock where IV fluids have been given continuously or intermittently must be cited in the medical chart.	NN, SN, PO, PPN, CP, Hospital records
K5b **ADL ONLY** (page 3-130)	Feeding Tube	Documented evidence of a feeding tube that can deliver food/nutritional substances/fluids/medications directly into the gastrointestinal system.	NN, SN, DN, PO, PPN, CP
P1b a,b,c Col. A,B (page 3-150)	Therapies	Days and minutes of each therapy must be cited in the medical chart on a daily basis to support the total days and minutes of direct therapy provided. (See page 16 for additional information.)	TN, PO
P3a-i **LOW INTENSITY ONLY** (page 3-155)	Nursing Rehab/ Restorative	Days of restorative nursing must be cited in the medical chart on a daily basis. Minutes of service must be provided daily to support the total time that is then converted to days on the MDS.	NR, NN, SN, CP

Very High Intensity	**High Intensity**	**Medium Intensity**	**Low Intensity**
450 minutes or more of therapy per week and one type of therapy at least five days a week and two or more therapies delivered.	300 minutes or more of therapy per week and one type of therapy at least five days a week delivered.	150 minutes or more of therapy per week and five days or more of one or a combination of therapy delivered.	45 minutes or more of therapy per week and three days or more of one or a combined therapy and two types or more of nursing restorative, five or more days per week.

ADL Score	**RUG-III**	**ADL Score**	**RUG-III**	**ADL Score**	**RUG-III**	**ADL Score**	**RUG-III**
14-18	**RVC**	**15-18**	**RHD**	**16-18**	**RMC**	**12-18**	**RLB**
8-13	**RVB**	**12-14**	**RHC**	**8-15**	**RMB**	**4-11**	**RLA**
4-7	**RVA**	**8-11**	**RHB**	**4-7**	**RMA**		
		4-7	**RHA**				

The EDS audit review includes in the review sample 100 percent of all residents and assessments classified in the Special Rehabilitation category.

To validate assessments in the Special Rehabilitation RUG-III category, the audit team should find only documentation that supports the ADL responses and the appropriate number of days or minutes of physical, occupational, and speech therapy, or nursing restorative modality provided during the assessment period. If one or more of these responses is not supported by the medical record documentation, and the audited values do not support the transmitted RUG-III classification, the record is in error. Record the number of days or minutes of therapy or nursing restorative measures that were documented in the resident's medical record. This number may be higher or lower than the value coded on the MDS.

Nursing restorative programs must meet all of the requirements in the *RAI Manual*, including documentation in minutes.

The coding is still correct if minutes are recorded in multiples of 15. If there is a possible trend to convert units to minutes, which may be indicative of *up coding*, this information should be noted in the narrative summary of the audit. This narrative is necessary to capture possible up-coding trends.

In addition to the *Supportive Documentation Guidelines*, the auditors should refer to the following helpful hints:

- The auditor may find it helpful to create a grid on the back of the worksheet, to duplicate therapy days and minutes for validation.
- Group minutes may be counted if the following criteria is met:
  - The group consists of four or fewer participants
  - The group therapy minutes do not exceed 25 percent of the total minutes recorded
  - Licensed therapy (P1B, a, b, and c) documentation reflects actual minutes of direct therapy time and must be validated to the minute. Evaluation minutes are not included; however, subsequent re-evaluation time may be reflected in the minutes coded on the MDS.
- Section "G", (ADLs) and section "P3" (nursing restorative) are not compared against each other in the RUG-III system. The audit process requires the provider to meet the using restorative RAI criteria, and to validate at least 15 minutes per day coded on the MDS.
- Nursing restorative minutes are estimated as close as possible for the actual time of service. Stopwatches are not required.

Remember that the facility must show proof of training for the staff; such as Certified Nursing Assistant (CNA) certification and/or any in-service training specific to the rehabilitation modality.

Myers & Stauffer will capture any RUG-III changes based on audit results. The office submits audit results to Myers & Stauffer after the conclusion of the audit.

Per *405 IAC 1-15-6***:** *Nursing facilities shall complete and transmit a new full MDS assessment for all residents after the conclusion of all physical, speech and occupational therapies. Such new full assessments shall be completed in order that the MDS assessment reference date (A3a) shall be no earlier than eight (8) days, and no later than ten (10) days after the conclusion of all physical, speech and occupation therapies. If the resident expires or is discharged from the facility, no such new assessment is required.*

The facility should code these assessments with a **6** in the A8b field on the MDS, unless the resident is on a Medicare Part A continued stay. In that case, the appropriate Medicare assessment code should be used.

If the audit reveals that no new assessment was completed after all physical, speech, and occupational therapies ended, this is considered to be an **untimely assessment**. An untimely assessment is considered to be a **record in error** and is noted as such on the audit worksheet. The audit team also records the date that all therapies ended in the *EOT Date* section.

Refer to the *RAI Manual* and documentation guidelines for more information.

Extensive Services

Table 2.8 – Extensive Services

MDS 2.0 Version 5.01			
Extensive Services			
MDS 2.0 Location	**Field Description**	**Charting Guidelines**	**Possible Chart Location**
G1a,b,i Col. A,B and G1h,A **ADL ONLY** (page 3-77, 3-78, 3-82)	Physical Functioning and Structural Problems ADLs	Four ADLs must be addressed in the medical chart for purposes of validating the MDS responses. These ADLs include bed mobility, transfer, toileting, and eating. Consider the resident's self-performance and support provided during all shifts, as functionality may vary.	NN, SSN, SN, CP, NR
K5a***** (page 3-130)	Parenteral/IV	Evidence of an IV or heparin lock where IV fluids have been given continuously or intermittently must be cited in the medical chart.	NN, SN, PO, PPN, CP, Hospital records
K5b **ADL ONLY** (page 3-130)	Feeding Tube	Documented evidence of a feeding tube that can deliver food/nutritional substances/fluids/medications directly into the gastrointestinal system.	NN, SN, DN, PO, PPN, CP
P1a,i***** (page 3-149)	Suctioning	Evidence of nasopharyngeal or tracheal aspiration must be cited in the medical chart. **Oral suctioning is not permitted to be coded in this field.**	NN, SN, PO, PPN, CP, TN, Hospital records
P1a,j***** (page 3-149)	Tracheostomy Care	Evidence of tracheostomy and cannula cleansing administered by staff must be cited in the medical chart.	NN, SN, PO, PPN, CP, TN, Hospital records
P1a,l***** (page 3-149)	Ventilator or Respirator	Evidence of ventilator or respirator assistance must be cited in the medical chart. Any resident who was in the process of being weaned off the ventilator or respirator in the last 14 days should be coded. Neither CPAP nor BiPAP are considered ventilator devices and are not considered for audit validation.	NN, SN, PO, PPN, CP, TN, Hospital records

Note: *At least one of the above treatments must be coded and have an ADL score of 7 or more. If the ADL score is 6 or less, the record will classify in the Clinically Complex group.

Treatments	RUG-III
3 or more	SE3
2	SE2
1	SE1

The EDS audit review sample includes 100 percent of all assessments that are classified in the Extensive Services category.

To validate assessments in the Extensive Services RUG-III category, the audit team confirms the documentation supporting the ADL responses. The audit team looks for additional elements as indicated in the supportive guidelines. In addition to the *Supportive Documentation Guidelines*, the following may be helpful:

- Suctioning that is self-performed by the resident is not acceptable for validation of the **P1ai** data field on the MDS.
- Tracheostomy (**P1a,j**) care is supported when there is a physician's order and documentation to verify that tracheostomy care was given at any time during the 14-day assessment period. Documentation must include that cannula care was provided.
- Neither CPAP nor BiPAP is an acceptable reason to code **P1al**.
- Hospital records with an electronically affixed physician's signature are acceptable for MDS audit purposes.
- All treatments that classify a resident in the Extensive Services category must be validated. Refer to treatment numbers as described in the classification process in the *Supportive Documentation Guidelines*.
- Refer to the *RAI Manual* and documentation guidelines for more information.

Special Care

Table 2.9 – Special Care

MDS 2.0 Version 5.01			
Special Care			
MDS 2.0 Location	**Field Description**	**Charting Guidelines**	**Possible Chart Location**
G1a,b,i Col. A,B and G1h,A **ADL ONLY** (page 3-77, 3-78, 3-82)	Physical Functioning and Structural Problems ADLs	Four ADLs must be addressed in the medical chart for purposes of validating the MDS responses. These ADLs include bed mobility, transfer, toileting, and eating. Consider the resident's self-performance and support provided during all shifts, as functionality may vary.	NN, SSN, SN, CP, NR
I1w***** (page 3-115)	Multiple Sclerosis	An active physician diagnosis must be present in the medical chart.	PO, PPN, NN, CP, SN, NR
I1z***** (page 3-112)	Quadriplegia	An active physician diagnosis must be present in the medical chart. Paralysis of all four limbs must be cited in the medical record. Usually caused by cerebral hemorrhage, thrombosis, embolism, tumor, or spinal cord injury.	PO, PPN ,NN, CP, SN, NR
I2g***** (page 3-116)	Septicemia	An active physician diagnosis must be present in the medical chart and **may be coded when blood cultures have been drawn but "results" are not yet confirmed**. Septicemia is a morbid condition associated with bacterial growth in the blood. Urosepsis is not considered for audit validation.	PO, PPN, NN, LAB, SN
K5a **ADL ONLY** (page 3-130)	Parenteral/IV	Evidence of an IV or heparin lock where IV fluids have been given continuously or intermittently must be cited in the medical chart.	NN, SN, PO, PPN, CP, Hospital records
K5b***** (page 3-130)	Feeding Tube	Documented evidence of a feeding tube that can deliver food/nutritional substances/fluids/ medications directly into the gastrointestinal system.	NN, SN, DN, PO, PPN, CP
M2a***** (page 3-135)	Pressure Ulcer (stage 3 or 4)	All pressure ulcers must be described and staged as they appear during the observation period on the MDS. This may require the stage to be increased or decreased from the previous MDS.	NN, SN, PO, PPN, CP, DN, TN, Wound record
M4b***** (page 3-137)	Burns	All second and third degree burns must be documented in the medical chart.	NN, SN, PO, PPN, CP, DN, TN, Skin sheet
P1a,c***** (page 3-149)	IV Medications	Documentation must be present in the medical chart.	NN, MAR, PO, CP, Hospital records

(Continued)

Table 2.9 – Special Care

MDS 2.0 Version 5.01			
Special Care			
MDS 2.0 Location	**Field Description**	**Charting Guidelines**	**Possible Chart Location**
P1a,h***** (page 3-149)	Radiation	Includes radiation therapy or a radiation implant. Documentation must be available in the medical chart.	NN, SN, PO, PPN, SSN, DN, CP, Hospital records
B1** (page 3-42)	Comatose	Must have a documented neurological diagnosis of coma or persistent vegetative state from physician.	PO, PPN, NN, CP, SN
N1d****** (page 3-141)	Time Awake (None of Above)	Evidence of time awake or nap frequency should be cited in the medical chart to validate the response.	NN, SN, PPN, CP, SSN, NR, CNAN
J1h** (page 3-120)	Fever	Recorded temperature 2.4 degrees greater than the baseline temperature. The route (rectal, oral, etc.) of temperature measurement must be consistent between the baseline and the elevated temperature.	NN, SN, Vital sign sheet
I2e** (page 3-116, 3-117)	Pneumonia	An active physician diagnosis must be present in the medical chart. Often there is a chest x-ray, medication order and notation of fever and symptoms.	PO, PPN, NN, SN, X-RAY
J1c** (page 3-119)	Dehydration; output exceeds input	Supportive documentation might include intake/output records and thorough nurses' documentation describing the resident's symptoms and/or fluid loss that exceeds intake.	PO, PPN, NN, CP, SN, LAB
J1o** (page 3-121)	Vomiting	Evidence must be cited in the medical chart.	NN, SN, SSN, PPN
K3a** (page 3-128)	Weight Loss	Documented evidence in the medical chart of the resident's weight loss as defined on the MDS.	NN, SN, DN, CP, SSN PPN, Weight sheet

****Special combination considerations:**

When B1=coma, all ADL self-performance (G1a,b,h,i) are coded with a 4 or 8 and time awake (N1d-None of Above) is checked.

When J1h, fever is checked, one of the following must also be checked; I2e, pneumonia; J1c, dehydration; J1o, vomiting; K3a, weight loss.

*At least one of the above conditions must be coded and have an ADL score of 7 or more. If the ADL score is 6 or less, the record will classify in the Clinically Complex group.

ADL Score	**RUG-III**
17-18	**SSC**
14-16	**SSB**
7-13	**SSA**

The EDS audit review sample includes 100 percent of all assessments that are classified in the Special Care category.

- **I1z Quadriplegia** is substantiated with collateral evidence, including observation, and a physician's diagnosis. Spastic quadriplegia does not always trigger quadriplegia, but a quadriplegic may be a spastic quad. Quadriparesis may not be coded as Quadriplegia. The *RAI Manual* specifies that to code **Ilz**, the resident must have a diagnosis of quadriplegia.
- Evidence of parenteral or IV administration of fluids is required to support the **K5a** data element on the MDS. Hospital records within the appropriate assessment time frame are acceptable.
- For MDS purposes, the *RAI Manual* requires that pressure ulcers (**M2a**) must be down staged. For example, a pressure ulcer, which was first documented as a Stage IV, but is now a Stage II, must be coded on the MDS as a Stage II.
- The EDS registered nurse auditor must observe all Stage III or IV pressure ulcers identified by the facility. This includes those coded and not coded on the MDS and applies only to residents whose names appear on the resident roster.
- Documentation in the medical record or hospital information should support second and third degree burns (**M4b**), and IV medications (**P1a,c**) when coded. Changes in skin color only, indicating a first-degree burn, should not be coded in this section of the MDS.
- Intravenous fluids without medication or heparin flushes are not included; however, these fluids are acceptable for Parenteral/IV (**K5a**) requirements.
- Evidence of radiation therapy that occurred in the appropriate time frame includes hospital or clinic information documenting therapy or implants.
- In addition to a diagnosis of comatose (**B1**), the entire medical chart must support a persistent vegetative state.
- Validation of dehydration (**J1c**) is supported when two or more of the indicators listed in the *RAI Manual*, page 3-119, are documented in the clinical record.
- Documentation of spitting out food or saliva is not supportive of vomiting (**J1o**).
- The nurse practitioner's signature is acceptable for diagnosis on the history and physical (H & P), M.D. orders, and so forth. An H & P up to one year old is acceptable for diagnosis, and the diagnosis

may also be obtained from a diagnosis list, if the list is current and signed by a physician within the past year.

- When more than one item classifies a resident in this category, the audit process does not require validation of all items. The auditor validates only the minimum required elements to classify the resident.

Refer to the *RAI Manual* and *Supportive Documentation Guidelines* for more information.

Clinically Complex

Table 2.10 – Clinically Complex

MDS 2.0 Version 5.01			
Clinically Complex			
MDS 2.0 Location	**Field Description**	**Charting Guidelines**	**Possible Chart Location**
G1a,b,i Col. A,B and G1h,A **ADL ONLY** (page 3-77, 3-78, 3-82)	Physical Functioning and Structural Problems ADLs	Four ADLs must be addressed in the medical chart for purposes of validating the MDS responses. These ADLs include bed mobility, transfer, toileting, and eating. Consider the resident's self-performance and support provided during all shifts, as functionality may vary.	NN, SSN, SN, CP, NR
I1r***** (page 3-111)	Aphasia	An active physician diagnosis must be present in the medical chart. Aphasia is defined as difficulty in communicating orally, through sign, or in writing, or the inability to understand such communication. This difficulty must be cited in the medical chart.	NN, SSN, SN, CP, PPN, PO
I1s***** (page 3-111)	Cerebral Palsy	An active physician diagnosis must be present in the medical chart. Paralysis related to developmental brain defects or birth trauma.	PO, PPN, NN, CP, SN
I1v***** (page 3-112)	Hemiplegia/ Hemiparesis	An active physician diagnosis must be present in the medical chart. Left or right-sided paralysis is acceptable as a diagnosis.	PO, PPN, NN, CP, SN, NR
I2e***** (page 3-116)	Pneumonia	An active physician diagnosis must be present in the medical chart. Often there is a chest x-ray, medication order and notation of fever and symptoms.	PO, PPN, NN, SN, X-RAY
I2j***** (page 3-116)	Urinary Tract Infection	Includes chronic and acute symptomatic infection(s) in the last 30 days. **Check this item only if there is current supporting documentation and significant laboratory findings in the clinical record.**	PO, PPN, NN, LAB, SN
J1c***** (page 3-119)	Dehydration; output exceeds input	Supportive documentation might include intake/output records and thorough nurses' documentation describing the resident's symptoms and/or fluid loss, which exceed intake.	PO, PPN, NN, CP, SN, LAB
J1j***** (page 3-120)	Internal Bleeding	Clinical evidence must be cited in the medical chart such as: black, tarry stools; vomiting "coffee grounds"; hematuria; hemoptysis; or severe epistaxis.	NN, SN, PO, PPN

(Continued)

Table 2.10 – Clinically Complex

MDS 2.0 Version 5.01			
Clinically Complex			
MDS 2.0 Location	**Field Description**	**Charting Guidelines**	**Possible Chart Location**
J1k***** (page 3-120)	Recurrent Lung Aspirations	Clinical indicators required in the medical chart might include: productive cough, shortness of breath, or wheezing.	NN, SN, PO, PPN, CP, X-RAY, TN
J5c***** (page 3-126)	End-stage Disease	A physician terminal diagnosis of a deteriorating clinical course is required in the medical chart.	PO, PPN, NN, SN, CP, SSN, Hospice notes
K5a***** **ADL ONLY** (page 3-130)	Parenteral/IV	Evidence of an IV or heparin lock where IV fluids have been given continuously or intermittently must be cited in the medical chart.	NN, SN, PO, PPN, CP, Hospital records
K5b **ADL ONLY** (page 3-130)	Feeding Tube	Documented evidence of a feeding tube that can deliver food/nutritional substances/fluids/ medications directly into the gastrointestinal system.	NN, SN, DN, PO, PPN, CP
M2b***** (page 3-135)	Stasis Ulcer (stage 1, 2, 3, or 4)	All stasis ulcers must be described and staged as they appear during the observation period on the MDS. This may require the stage to be increased or decreased from the previous MDS.	NN, SN, PO, PPN, CP, DN, TN, Wound record
P1a,a***** (page 3-148)	Chemotherapy	Includes any type of chemotherapy (anticancer drug) given by any route. Evidence must be cited in the medical chart.	NN, SN, PO, PPN, CP, DN, SSN, MAR, Hospital records
P1a,b***** (page 3-149)	Dialysis	Includes peritoneal or renal dialysis that occurs at the nursing facility or at another facility. Evidence must be cited in the medical chart.	NN, SN, PO, PPN, CP, DN, SSN, Hospital records
P1a,g***** (page 3-149)	Oxygen Therapy	Oxygen therapy shall be defined as the administration of oxygen continuous or intermittent via mask, cannula, and so forth. Evidence must be cited on the medical chart.	NN, SN, PO, PPN, CP, SSN, TN, Hospital records
P1a,k***** (page 3–149)	Transfusions	Evidence of transfusions of blood or any blood products administered by staff must be cited in the medical chart.	NN, SN, PO, PPN, CP, Hospital records
P1b,d A***** (page 3-151)	Respiratory Therapy	Days and minutes of respiratory therapy must be cited in the medical chart on a daily basis to support the total days and minutes of direct therapy provided.	TN, PO

(Continued)

Table 2.10 – Clinically Complex

MDS 2.0 Version 5.01			
Clinically Complex			
MDS 2.0 Location	**Field Description**	**Charting Guidelines**	**Possible Chart Location**
P8***** (page 3-161)	Physician Orders (4 or more)	Includes written, telephone, fax, or consultation orders for new or altered treatment. Does NOT include admission orders, return admission orders, or renewal orders without changes.	PO, PPN
M4c****** (page 3-137)	Open Lesions other than ulcers, rashes, cuts	All open lesions must be documented in the medical chart. Documentation might include appearance, measurement, treatment, color, odor, and so forth.	NN, SN, PO, PPN, CP, DN, TN, Skin sheet
M4f****** (page 3-138)	Skin Tears or Cuts	A skin tear or cut is any traumatic break in the skin penetrating to subcutaneous tissue. Documentation might include appearance, measurement, treatment, color, odor, and so forth.	NN, SN, PO, PPN, CP, DN, TN, Skin sheet
M5i****** (page 3-139)	Other preventative or protective skin care (other than to feet)	Includes application of creams or bath soaks to prevent dryness, scaling; application of protective elbow pads, etc. Evidence of preventive or protective care must be documented in the medical chart.	NN, SN, PO, PPN, CP, TN, NR, Skin sheet, Treatment sheet
M6f** (page 3-140)	Applications of Dressings (feet)	Evidence of dressing changes to the feet must be documented in the medical chart.	NN, SN, PO, PPN, CP, TN, Skin sheet, Treatment sheet
M4g** (page 3-138)	Surgical Wounds	Includes healing and non-healing, open or closed surgical incisions, skin grafts or drainage sites on any part of the body. Documentation might include appearance, measurement, treatment, color, odor, and so forth. Does not include healed surgical sites or stomas.	NN, SN, PO, PPN, CP, DN, TN, Skin sheet
M5f** (page 3-139)	Surgical Wound Care	Includes any intervention for treating or protecting any type of surgical wound. Evidence of wound care must be documented in the medical chart.	NN, SN, PO, PPN, CP, DN, TN, Skin sheet
**Special combination considerations: M4c, open lesions must also include coding for M5i, other skin care or M6f, foot dressings. M4f, skin tears/cuts must also include coding for M5i, other skin care or M6f, foot dressings.			
*The resident must qualify for one of the above conditions. The resident who met criteria for Extensive Services or Special Care but the ADL score was below 7 would classify as Clinically Complex. Once classified in Clinically Complex, next the resident is evaluated for Depression using the items in Table 2.11.			

The EDS audit team is responsible for reviewing at least 10 Clinically Complex residents or 100 percent if less than 10 Clinically Complex residents are listed on the resident roster.

In addition to the charting guidelines outlined in Table 2.10, the audit team should use the following as helpful hints when validating documentation:

- Validation of dehydration (**J1c**) is supported when two or more of the indicators listed in the *RAI Manual*, page 3-119, are documented in the clinical record.
- An anti-cancer drug prescribed and administered for a diagnosis other than cancer may acceptably be coded as chemotherapy (**P1a,a**).
- The audit team validates, at minimum, documentation that reflects 15 direct care minutes per day for each day of respiratory therapy (**P1b,d,A**). Direct care respiratory therapy may be performed by any trained staff member. The care may exceed 15 minutes per day.
- Physician orders include not only the primary MD, but also all physicians directing some aspect of that resident's care.
- H & Ps up to one year old are acceptable for diagnostic information during the audit. In addition, this information may be obtained from a diagnosis list, if the list is current and is signed by a physician within the past twelve months. A nurse practitioner's signature is acceptable for diagnosis on H & Ps, M.D. orders, and so forth.
- The intent of the **P8** data element on the MDS is to reflect the number of days during the last 14 days a physician has changed a resident's orders. For example, there may be five new orders in one day. These are counted as one day for coding the MDS.
- When more than one item classifies a resident in this category, the audit process does not require validation of all items. The auditor validates only the minimum required elements to classify the resident.

Refer to the *RAI Manual* and documentation guidelines for more information.

Depression

Table 2.11 – Depression Elements

MDS 2.0 Version 5.01			
Clinically Complex – Depression Elements			
MDS 2.0 Location	**Field Description**	**Charting Guidelines**	**Possible Chart Location**
E2 (page 3-60)	Mood Persistence (1 or 2)	Of the indicators described in E1, the medical chart must cite the results of attempts to alter the indicator(s)	NN, SSN, SN, NR, CP
E1a,g,j,n,o,p (page 3-58 to 3-60)	Indicators of Depression, Anxiety, Sad Mood (1 or 2***)***	Examples of verbal and/or non-verbal expressions of distress i.e., depression, anxiety, and sad mood must be found in the medical chart. See MDS (E1) for specific details.	NN, SSN, SN, NR, CP
E4e Col.A (page 3-62 to 3-65)	Behavioral Symptoms (1, 2, or 3)	Acknowledgment and examples of the resident's behavior symptom patterns must be provided in the medical chart. The record must reflect daily behavioral symptoms manifested by the resident.	NN, SSN, SN, NR, CP
N1d (page 3-141)	Time Awake (None of Above)	Evidence of time awake or nap frequency should be cited in the medical chart to validate the answer.	NN, SN, PPN, CP, SSN, NR, CNAN
N1a,b,c (page 3-141)	Time Awake (total checked equal 0 or 1)	Evidence of time awake or nap frequency should be cited in the medical chart to validate the answer.	NN, SN, PPN, CP, SSN, NR, CNAN
B1 (page 3-42)	Comatose (equal 0)	Must have a documented neurological diagnosis of coma or persistent vegetative state from physician.	PO, PPN, NN, CP, SN
K3a (page 3-128)	Weight Loss	Documented evidence in the medical chart of the resident's weight loss as defined on the MDS.	NN, SN, DN, CP, SSN, PPN, Weight sheet
I1ee (page 3-114 to 3-115)	Depression	An active physician diagnosis must be present in the medical chart.	PO, PPN, NN, CP, SN, SSN
I1ff (page 3-312)	Manic Depression (bipolar disease)	An active physician diagnosis must be present in the medical chart.	PO, PPN, NN, CP, SN, SSN

(Continued)

Table 2.11 – Depression Elements

MDS 2.0 Version 5.01

Clinically Complex – Depression Elements

DEPRESSION EVALUATION

The resident is considered depressed if he/she meets either a combination of group **A** or group **B** of the following criteria:

GROUP A

E2 Persistent sad mood (1 or 2) and two other symptoms (only one symptom can be counted from groups 2 and 3):

1. E1a – Negative statements (1 or 2) (page 3-58)
2. E1n – Repetitive movements (1 or 2) (page 3-59)
   E1o – Withdrawal (1 or 2) (page 3-59)
   E1p – Reduced interaction (1 or 2) (page 3-59)
   E4eA – Resists care (1,2, or 3) (page 3-63)
3. E1j – Unpleasant AM mood (1 or 2) (page 3-59)
   N1d – Time awake (checked) (page 3-141)
   N1a,b,c – Awake only morning, afternoon,
   or evening (total checked = 0 or 1) and B1=0 (page 3-141)
4. E1g – Terrible future (1 or 2) (page 3-59)
5. K3a – Weight loss (page 3-128)

"OR"

GROUP B

(I1ee) Depression and one symptom from the items above **<u>or</u>** (I1ff) Bipolar disease and **one** symptom from the items above. (page 3-112)

ADL Score	Depressed	RUG-III
17-18	**YES**	**CD2**
17-18	**NO**	**CD1**
11-16	**YES**	**CC2**
11-16	**NO**	**CC1**
6-10	**YES**	**CB2**
6-10	**NO**	**CB1**
4-5	**YES**	**CA2**
4-5	**NO**	**CA1**

Depression elements are a component of the Clinically Complex RUG category. If the resident meets one of the Clinically Complex conditions listed in Table 2.10, the audit team evaluates for depression.

In addition to the documentation guidelines, the audit team should consider the following:

- Documentation to support depression elements must reflect examples of the resident's mood during the seven-day assessment period.
- *Alzheimer's with depressed mood*, is not an acceptable diagnosis to be coded in the **I1ee** field on the MDS.
- If more than one MDS element in Group A, #2 and/or #3 is coded, the auditor is only required to validate one element in each.

Refer to the *RAI Manual* for additional information

Impaired Cognition

Table 2.12 - Impaired Cognition

MDS 2.0 Version 5.01			
Impaired Cognition			
MDS 2.0 Location	**Field Description**	**Charting Guidelines**	**Possible Chart Location**
G1a,b,i Col. A,B and G1h,A **ADL ONLY** (page 3-77, 3-78, 3-82)	Physical Functioning and Structural Problems ADLs	Four ADLs must be addressed in the medical chart for purposes of validating the MDS responses. These ADLs include bed mobility, transfer, toileting, and eating. Consider the resident's self-performance and support provided during all shifts, as functionality may vary.	NN, SSN, SN, CP, NR
B2a***** (page 3-42)	Short Term Memory	Short-term memory loss must be supported in the body of the medical chart with specific examples of the loss. (E.g., can't describe breakfast meal or an activity just completed). If there is no positive indication of memory ability, documentation must be cited in the medical record.	NN, SSN, SN, NR, CP
B3a-d***** (page 3-43)	Memory/ Recall Ability	Examples of the resident's memory/recall performance within the environment or circumstances must be found in the medical chart. (E.g., ask the resident "what is the current season, what is the name of this place or what kind of place this is.")	NN, SSN, SN, NR, CP
B4***** (page 3-44)	Cognitive Skills for Daily Decision Making	Citations or examples must be found in the medical chart of the resident's ability to actively make decisions, and not whether staff believe the resident might be capable of doing so.	NN, SSN, SN, NR, CP
H3a **NURSING RESTORE SCORE ONLY** (page 3-108)	Any Scheduled Toileting Plan	Evidence in the medical chart must support a plan whereby staff members at scheduled times each day take the resident to the toilet, give the resident a urinal, or remind the resident to go to the toilet.	NN, NR, SN, CP, CNAN
P3a-i **NURSING RESTORE SCORE ONLY** (page 3-155)	Nursing Rehab/ Restorative	Days of restorative nursing must be cited in the medical chart on a daily basis. Minutes of service must be provided daily to support the program and total time that is then converted to days on the MDS.	NR, NN, SN, CP
Nursing Restorative care (P3) counts as a score of 1 for each item (P3 a,b,c,e,g,h,i) with an entry of five or more days of activity. P3d and/or P3f may be counted as a score of 1, but do not count both. Additionally, if any toileting plan (H3a) is checked, add a score of 1 to the Nursing Restorative Score.			

(Continued)

Table 2.12 - Impaired Cognition

MDS 2.0 Version 5.01		
Impaired Cognition		
Total ADL score must be 10 or less. The following criteria combination must be met: *B2a Short term memory = 1 and B3a-d Memory/Recall (any **not** checked) and B4 Decision making (1, 2, or 3)		
ADL Score	**Nursing Restorative Score**	**RUG-III**
6-10	**2 or more**	**IB2**
6-10	**0 or 1**	**IB1**
4-5	**2 or more**	**IA2**
4-5	**0 or 1**	**IA1**

The EDS audit team is responsible for reviewing five records, or 100 percent, if less than five, in the Impaired Cognition RUG-III category.

In addition to the *Supportive Documentation Guidelines*, the audit team should consider the following:

- The narrative documentation throughout the medical record may be indicative of the resident's short-term memory (**B2a**), recall (**B3a-d**), and decision-making skills (**B4**) without specifically responding to the question on the MDS. For example, "the resident cannot recall the season" could be documented as "the resident came to the 4th of July cookout wearing her coat, gloves, and earmuffs."
- With regard to recall ability (**B3a-d**), the audit team must find supportive documentation to indicate examples of what the resident is unable to do rather than what the resident actually is able to do.
- Nursing restorative care (**P3**) counts as a score of one for each item (**P3a,b,c,e,g,h,i**) with an entry of five or more days of activity. **P3d** or **P3f** may be counted as a score of one but both may not be counted. Additionally, if any toilet use plan (**H3a**) is checked a score of one is added to the nursing restorative score.
- When two or more programs are involved, the auditor needs to validate a minimum of two programs.
- The record is not in error if the number of days and minutes exceed five and 15.
- If zero or one nursing restorative program is involved, the auditor is not required that portion of the record. The auditor records **N/A** in the **Transmitted Value** box on the worksheet.

- To validate the nursing rehabilitation and restorative section (**P3**) of the MDS, all criteria described on page 3-154 of the *RAI Manual* must be met.
- Section **G**, ADLs, and section **P3** are not compared against each other in the RUG-III system. For example, a resident may be independent with ADLs yet be receiving nursing restorative services. The audit process requires the provider to meet the nursing restorative RAI criteria and to validate at least 15 minutes per day coded on the MDS.
- Nursing restorative minutes should be estimated as accurately as possible for the actual time of service. Rounding to the nearest whole minute is acceptable. Stopwatches are not required.
- The facility must show proof of training for the staff; such as CNA certification and any in-service training specific to the rehabilitation modality.
- Verify that the nursing restorative program is addressed on the care plan and that the record indicates evidence of periodic evaluation by a licensed nurse.
- Evidence of a plan or program administration for scheduled toilet use of the resident, is acceptable documentation for validation of any scheduled toilet use plan (**H3a**).

Refer to the *RAI Manual* and *Supportive Documentation Guidelines* for more information.

Behavior Problems

Table 2.13 – Behavior Problems

MDS 2.0 Version 5.01			
Behavior Problems			
MDS 2.0 Location	**Field Description**	**Charting Guidelines**	**Possible Chart Location**
G1a,b,i Col. A,B and G1h,A **ADL ONLY** (page 3-77, 3-78, 3-82)	Physical Functioning and Structural Problems ADLs	Four ADLs must be addressed in the medical chart for purposes of validating the MDS responses. These ADLs include bed mobility, transfer, toileting, and eating. Consider the resident's self-performance and support provided during all shifts, as functionality may vary.	NN, SSN, SN, CP, NR
E4a,b,c,d***** Col.A (page 3-62 to 3-65)	Behavioral Symptoms	Acknowledgment and examples of the resident's behavior symptom patterns must be provided in the medical chart. The record must reflect daily behavioral symptoms manifested by the resident.	NN, SSN, SN, NR, CP
H3a **NURSING RESTORE SCORE ONLY** (page 3-108)	Any Scheduled Toileting Plan	Evidence in the medical chart must support a plan whereby staff members at scheduled times each day either take the resident to the toilet room, or give the resident a urinal, or remind the resident to go to the toilet.	NN, NR, SN, CP, CNAN
J1e***** (page 3-120)	Delusions	Evidence in the medical chart must describe examples of resident's fixed, false beliefs not shared by others even when there is obvious proof or evidence to the contrary.	PO, PPN, NN, SN, CP, SSN
J1i***** (page 3-120)	Hallucinations	Evidence in the medical chart that describes examples of resident's auditory, visual, tactile, olfactory or gustatory false perceptions that occur in the absence of any real stimuli.	NN, SN, PO, PPN, SSN, CP
P3a-i **NURSING RESTORE ONLY SCORE** (page 3-155)	Nursing Rehab/ Restorative	Days of restorative nursing must be cited in the medical chart on a daily basis. Minutes of service must be provided daily to support the program and total time is then converted to days on the MDS.	NR, NN, SN, CP
Nursing Restorative care (P3) counts as a score of 1 for each item (P3 a,b,c,e,g,h,i) with an entry of five or more days of activity. P3d and/or P3f may be counted as a score of 1, but do not count both. Additionally, if any toileting plan (H3a) is checked, add a score of 1 to the Nursing Restorative Score.			

(Continued)

Table 2.13 – Behavior Problems

MDS 2.0 Version 5.01		
Behavior Problems		
Total ADL score must be 10 or less. *One of the above must be coded.		
ADL Score	**Nursing Restorative Score**	**RUG-III**
6-10	**2 or more**	**BB2**
6-10	**0 or 1**	**BB1**
4-5	**2 or more**	**BA2**
4-5	**0 or 1**	**BA1**

The EDS audit team is responsible for auditing five records, or 100 percent of the patients, if less than five, in the Behavior Problems RUG-III classification.

In addition to the *Supportive Documentation Guidelines,* the audit team should consider the following:

- Behavior logs are acceptable as long as the log is descriptive and keys or definitions are present where applicable.
- Examples of specific resident behaviors and the frequency of occurrence should be cited in the clinical record. Refer to *the RAI Manual*, *Section E4,* for definitions of these behaviors and coding requirements.
- Nursing restorative care (**P3**) counts as a score of one for each item (**P3a,b,c,e,g,h,i**) with an entry of five or more days of activity. **P3d** or **P3f** may be counted as a score of one but not both. Additionally, if any toilet use plan (**H3a**) is checked, add a score of one to the nursing restorative score.
- When two or more programs are involved, the auditor only needs to validate two programs.
- The record is not in error if the number of days and minutes exceed five and 15.
- If zero or one nursing restorative program is involved, the auditor is not required to validate the program, and **N/A** is entered in the **Transmitted Value** box on the worksheet.
- To validate the nursing rehabilitation and restorative section (**P3**) of the MDS, all criteria describe on page 3-154 of the *RAI Manual* must be met.

- Sections **G**, ADLs, and **P3** are not compared against each other in the RUG-III system. For example, a resident may be independent with ADLs yet still be receiving nursing restorative services.
- The MDS is valid when all components listed in the *RAI Manual* are documented.
- Nursing restorative minutes should be estimated as closely as possible for the actual time of service. Rounding to the nearest whole minute is acceptable. Stopwatches are not required.
- The facility must show proof of training for the staff; such as CNA certification and/or any in-service training specific to the rehabilitation modality.
- Evidence of administration of a plan or program for scheduled toilet use for the resident is acceptable documentation for validation of **H3a**.

Refer to the *RAI Manual* and *Supportive Documentation Guidelines* for more information.

Reduced Physical Functioning

Table 2.14 – Reduced Physical Function

MDS 2.O VERSION 5.01			
REDUCED PHYSICIAL FUNCTION			
MDS 2.0 Location	**Field Description**	**Charting Guidelines**	**Possible Chart Location**
G1a,b,i Col. A,B and G1h,A **ADL ONLY** (page 3-77, 3-78, 3-82)	Physical Functioning and Structural Problems ADLs	Four ADLs must be addressed in the medical chart for purposes of validating the MDS responses. These ADLs include bed mobility, transfer, toileting, and eating. Consider the resident's self-performance and support provided during all shifts, as functionality may vary.	NN, SSN, SN, CP, NR
H3a **NURSING RESTORE ONLY SCORE** (page 3-108)	Any Scheduled Toileting Plan	Evidence in the medical chart must support a plan whereby staff members at scheduled times each day either take the resident to the toilet room, or give the resident a urinal, or remind the resident to go to the toilet.	NN, NR, SN, CP, CNAN

(Continued)

Table 2.14 – Reduced Physical Function

MDS 2.O VERSION 5.01			
REDUCED PHYSICIAL FUNCTION			
MDS 2.0 Location	**Field Description**	**Charting Guidelines**	**Possible Chart Location**
P3a-i **NURSING RESTORE ONLY SCORE** (page 3-155)	Nursing Rehab/Restorative	Days of restorative nursing must be cited in the medical chart on a daily basis. Minutes of service must be provided daily to support the program and total time which is then converted to days on the MDS.	NR, NN, SN, CP
Nursing Restorative care (P3) counts as a score of 1 for each item (P3 a,b,c,e,g,h,i) with an entry of 5 or more days of activity. P3d and/or P3f may be counted as a score of 1, but do not count both. Additionally, if any toileting plan (H3a) is checked, add a score of 1 to the Nursing Restorative Score.			

ADL Score	**Nursing Restorative Score**	**RUG-III**
16-18	**2 or more**	**PE2**
16-18	**0 or 1**	**PE1**
11-15	**2 or more**	**PD2**
11-15	**0 or 1**	**PD1**
9-10	**2 or more**	**PC2**
9-10	**0 or 1**	**PC1**
6-8	**2 or more**	**PB2**
6-8	**0 or 1**	**PB1**
4-5	**2 or more**	**PA2**
4-5	**0 or 1**	**PA1**

The EDS audit team is responsible for reviewing five records, or 100 percent, if less than five patients are in the Reduced Physical Functioning RUG-III category.

Residents who do not meet the conditions of any of the earlier categories, including those who would meet the criteria for the Impaired Cognition or Behavior Problems categories but have a RUG-III ADL score greater than 10, are placed in this category.

Refer to the *Supportive Documentation Guidelines* and the following:

- Nursing restorative care (**P3**) counts as a score of one for each item (**P3a,b,c,e,g,h,i**) with an entry of five or more days of activity. **P3d** or **P3f** may be counted as a score of one but do not count both. Additionally, if any toilet use plan (**H3a**) is checked, add one to the nursing restorative score.

- When two or more programs are involved the auditor only needs to validate two programs.
- The record is not in error if the number of days and minutes exceed the minimum of five and 15.
- If zero or one nursing restorative program is involved, the audit is not required to validate the program, and **N/A** is recorded in the **Transmitted Value** box on the worksheet.
- To validate the nursing rehabilitation and restorative section (**P3**) of the MDS, all criteria described on page 3-154 of the *RAI Manual* must be met.
- Sections **G,** ADLs, and **P3** are not compared to each other in the RUG-III system. For example, a resident may be independent with ADLs yet still receive nursing restorative services.
- The audit process requires the provider to meet the nursing restorative RAI criteria and to validate at least 15 minutes per day on the MDS.
- Minutes should be estimated as closely as possible for the actual time of service. Rounding to the nearest whole minute is acceptable. Stopwatches are not required.
- The facility must show proof of training for the staff; such as CNA certification and any in-service training specific to the rehabilitation modality.

Table 2.15 – Documentation Sources

Abbreviation	Definition
CNAN	Certified Nursing Assistant Notes
CP	Care Plan
DN	Dietary Notes
LAB	Laboratory
MAR	Medicine Administration Record
NN	Nurses Notes
NR	Nursing Restorative
PO	Physician's Orders
PPN	Physician Progress Notes
SN	Summary Notes (nurse)
SSN	Social Service Notes
TN	Therapy Notes

Special Notes About Documentation

- The H & P may be an excellent source of supportive documentation for any of the RUG-III elements.
- Any responses on the MDS 2.0 that reflect the resident's hospital stay prior to admission must be supported by hospital supportive documentation and placed in the resident's medical chart.
- Supportive documentation in the medical chart must be dated during the assessment reference period to validate the MDS 2.0 responses. The assessment reference period is established by identifying the assessment reference date (**A3a**) and the previous six days. On certain MDS questions, the reference period may be greater than or less than seven days.
- Responses on the MDS 2.0 must be from observations taken by all shifts during the specified assessment reference period.
- Old, unrelated diagnoses or diagnoses that do not meet the definition on the MDS 2.0 for Section I1 should not be coded on the MDS.
- Facilities must complete a new assessment after the cessation of all therapies when the preceding assessment is in the Rehabilitation category (Rule *405 IAC 1-15-6*).
- Rehabilitation or restorative care includes nursing interventions that assist or promote the resident's ability to attain his or her maximum functional potential. It does not include procedures under the direction and delivery of qualified, licensed therapists.
- Effective October 1, 1999, ADL documentation must represent all shifts during the assessment period.
- Information contained in the clinical record must be consistent and cannot conflict with the MDS.
- Group therapy is limited to four residents per session and only 25 percent of the total therapy minutes may be contributed to group therapy.

The following elements must be included in a nursing restorative program to meet the RAI restorative criteria:

- Measurable objectives and interventions must be documented in the care plan and clinical record.
- Evidence of periodic evaluation by a licensed nurse must be present in the clinical record.
- Nurse assistants and aides must be trained in the techniques that promote resident involvement in the activity.

- The activity must occur for at least 15 minutes in a 24-hour period to be documented on the MDS. The 15 minutes per day do not have to occur consecutively. For example, the activity could be five-minute intervals of activity at three different times during the day.
- The nursing restorative category does not apply to exercise groups of more than four residents.
- Refer to pages 3-153 to 3-157 of the *RAI Manual* for further clarification.

Level-of-care Review

During the process of the Case Mix Reimbursement review, the audit team reviews all pertinent medical documentation related to the resident's MDS and RUG-III level. In this review, the audit team makes note of whether the resident meets the minimum facility level-of-care criteria found in *405 IAC 1-3-1* and *405-IAC 1-3-2* to continue placement in the facility. Either **Y** (Yes) or **N** (No) is circled on the **Meets NF Criteria** section of the worksheet. If the resident does not meet minimum criteria for IHCP reimbursement in the facility, the audit team recommends **Discharge** on the audit worksheet and notes this on the *MAI* form. (*See Figure 2.7 – LOC Payment Review Worksheet*)

Currently, there are only a few nursing facilities in Indiana that are not subject to the Case Mix Reimbursement system. For all IHCP and IHCP-pending residents in these facilities, the auditor follows the PASRR review process and Level-of-care (LOC) criteria review **only**. Through a thorough review of the resident's medical records, the audit team determines the appropriate level-of-care required. These nursing facilities are reimbursed per resident per diem either by their intermediate LOC rate or skilled LOC rate. It is imperative that the audit team review the skilled and intermediate criteria for each resident, starting with the level-of-care that the resident is currently certified for.

The following subsection outlines the skilled and intermediate criteria. **These are not the full IAC citations, but a paraphrased working version for the audit team** which gives the audit team an objective basis to determine whether to transfer or discharge the resident from the current LOC. A resident can only be transferred in one of these nursing facilities. That is, the IHCP resident can be transferred from intermediate to skilled LOC, or skilled to intermediate LOC. In all nursing facilities, residents who do not meet the necessary criteria

found in *405 IAC 1-3-1* or *405 IAC 1-3-2* may be discharged from IHCP reimbursement in the nursing facility.

> *NOTE: Refer to the* Eligibility Screen and Definitions *for criteria interpretation regarding skilled and intermediate LOC.*

LEVEL OF CARE PAYMENT REVIEW/PASRR/NURSING FACILITIES

Payment Review ( )

PASRR/NR ( )

A. HEADER
Fac. PN
Add. ADM ___/__/__
City
Resident B/D __/___/___
RID Number MD
Diagnosis

B. Chart Review-Information Obtained From:
1. Physician Orders Y N
2. Progress Notes Y N
3. Nurses Notes Y N
4. Current MDS Y N
5. Medical History/Physical Y N
6. Care Plan Y N
7. Level of Care Certification Present Y N In Process / /
Effective Date / / Correct for current LOC Y N
Last Physician LOC Certification Date / /
COMMENTS

8. Social History/Physical Y N
9. Social/Activity Progress Note Y N
10. Special Ed Wksh Beh. Mod
11. Previous Residence
12. Previous State Hospital Adm. Y N
COMMENTS

C1. PASRR LEVEL II
Last Levell II Date / / /
MI/DD Y N
Diagnosis Svcs. Prov Y N
Recommendation :
N.F. Needed No N.F. Needed
MI/DD YES NO
Diagnosis: Svcs. Provided: Y N
Recommendation :
N.F. Needed No. N.F. Needed

Ver. 1099

I = Independent S= Supervision A= Assist D = Dependent
E. FUNCTIONS/BEHAVIORS F. Medication s & Treatment
1. Bath I S A D
2. Dress I S A D
3. Eating I S A D
4. Pers. Hyg I S A D
5. Mobility I S A D
W/C Self Prop Staff
Cane Walker Bedfast G/C
Other
6. Blind Part Deaf HOH
7. Communication V NV Aph
Other
8. Incont Urin e Stool Cath
9. Restraints Yes No
10. Alert x Confused
11. Oriented x Hallucinates H.405 IAC I. 405 IAC
12. Aggressive x Hostile 1-3-1-SK 1-3-2-IC
13. Disorient x Combative A A
14. Forgetful x Agitated B B_1_2_3_4_5_6
15. Seizures: Y N Frequency C C_1_2_3_4_5_6
16. Hospital __/__/__ - __/__/__ D _7_8_9_10_
DX E _11_12
17. Restor Serv Pt ST OT RT F_1_2_3_4 D
5_6_7
Frequency of G
Tube Fed I.V. T.P.N. VENT SUCTION OSTOMY
F. VITS OINTS GI DRUGS EAR/EYE GTTS PRN MEDS
G. LABS
H. DIET Reg. VS WT
J. OBSERVATIONS OF PATIENT
Social Functioning Yes No
Cleanliness Yes No
Satisfactory Nutrition/Hydration Yes No
Decubitus Yes No Describe TX
Medical Condition Stable Unstable
K. Level Determination Continue Transfer D/C
COMMENTS P
H
T
R

Reviewing Personnel ___/___/___ Review Date ___/___/___
Reviewing Physician
Agree Disagree Review Date ___/___/___

Figure 2.7 – LOC Payment Review Worksheet

405 IAC 1-3-1 Skilled Nursing Services; Unskilled Services

The audit team circles those criteria applicable to the resident being reviewed on the LOC Payment Review worksheet:

- Skilled nursing services, as ordered by a physician, must be required and provided on a daily basis—essentially, seven days a week.
- Rehabilitation services for an acute rehabilitative condition may be provided at either a skilled or intermediate LOC, depending on the resident's overall condition and nursing care needs. To qualify for skilled rehabilitation services, the following conditions must be met:
  - The services are ordered by a physician and must be required and provided at least five days a week.
  - The therapy must be of such complexity and sophistication that the judgment, knowledge, and skills of a licensed therapist are required.
  - The overall condition of the patient must be such that the judgment, knowledge, and skills of a licensed therapist are required.
- If the patient's overall condition requires assessment by professional nursing staff to evaluate the need for modification of treatment or initiation of other medical procedures until the patient's condition is stabilized, the service is at **the skilled level-of-care**. The physician orders, progress notes, and nurse's notes must document these services. Routine or prophylactic monitoring of a stable condition is considered **intermediate level-of-care**.
- When licensed professional nursing staff is required to teach a skilled procedure to facilitate discharge to self-care, the skilled level-of-care can be considered short-term. Training programs of longer than 30 days, when no other skilled services are required, are considered **intermediate level-of-care**.
  - Document the type of training program: for example, self-injection, self-catheterization, catheter care, ostomy care, dressing change, or suctioning.
  - Record any improvements in self-maintenance in the *Comments* section of the worksheet.
  - Nursing care plan and documentation of overall condition must substantiate that discharge to self-care following a training program is a realistic goal.
- The development, management, and evaluation of a patient care plan, based on physician orders, constitutes skilled services when, in terms of the patient's physical or mental condition, these services require the involvement of technical or professional personnel to meet the patient's medical needs, promote recovery, and ensure medical safety. However, planning and management of a treatment plan and supervision of personal care does not require skilled level-of-care. **Skilled level-of-care** is appropriate when the total of unskilled services that are a necessary part of the medical regimen, *considered in light of the patient's overall condition*, makes the *significant*

involvement of skilled nursing personnel necessary to promote the patient's recovery and medical safety. The need for *significant* skilled personnel involvement must be documented in the patient's medical record.

- Examples of skilled nursing services include, but are not limited to, the following:
  - *IV infusions or IV and intramuscular (IM) injections*—However, injections that can usually be self-administered, such as the well-regulated diabetic's daily insulin injections, would not require skilled services. The occasional or PRN IM injection qualifies as a skilled service only if the patient's medical condition is unstable as supported by documentation in the patient's medical record.
  - *Nasogastric tube and gastrostomy tube feedings*
  - *Nasopharyngeal and tracheostomy aspiration*—Patients with trach tubes that have been used over a long period of time and who are mentally able to perform this care with little, if any, supervision do not qualify for a skilled level-of-care.
  - *Insertion and sterile irrigation or replacement of catheters*—Skilled care may be required for patients with frequent catheter obstructions that necessitate the intervention of professional personnel. The sterile irrigation of catheters must be ordered by a physician who must specify the type of irrigation and the length of time that the sterile irrigation is to continue. Routine, sterile irrigations for more than 14 days are considered **intermediate level-of-care**.
  - *Complex wound care involving sterile dressings, prescription medications, and aseptic technique*—Justification for these procedures must be fully documented, and the physician must specify the duration of these treatments. If treatments are necessary longer than 30 days this necessity must be documented in the patient's medical record.
  - *Care of extensive decubitus ulcers*—The size and stage of each ulcer must be documented. The physician must specifically order the treatment, and appropriate documentation of the progress of the ulcer is required. Stage III and IV decubitus ulcers qualify as extensive and must be observed by the EDS registered nurse to confirm current staging.
  - *Initial phases of a regimen involving the administration of oxygen (O_2).* Patients requiring O_2 on a daily basis for a new or recent medical condition qualify for **skilled LOC**. However, patients receiving O_2 either continuously or PRN (as needed) for a chronic, stable medical condition do not qualify for skilled LOC.
- Documentation of the medical necessity for increased intensity of nursing services must be noted in the physician's orders, progress notes, and nurse's notes to qualify for **skilled LOC**. Intermediate LOC can be justified when skilled LOC intensity of nursing services is no longer required.

405 IAC 1-3-2 Intermediate Level-of-care Criteria

The audit team circles those criteria applicable to the resident being reviewed on the LOC Payment Review worksheet:

- Intermediate nursing care includes care for patients with long-term illnesses or disabilities that are relatively stable or care for patients nearing recovery and discharge who continue to require some professional medical or nursing supervision and intervention. Intermediate care services encompass a range of services from those below skilled level-of-care to those above room and board level-of-care. The determination of the differences between the skilled and intermediate LOC is based on the patient's condition as well as the complexity and range of medical services required by the patient daily. The provision of room, food, laundry, and supervision of ADLs do not qualify as intermediate LOC by themselves.
- Intermediate care includes room, food, laundry, and professional supervision of activities for protection and safety, along with combinations of the following:
  - Assistance with ambulation
  - Assistance with transferring and positioning
  - Assistance with general hygiene
  - Assistance with eating
  - Assistance with dressing
  - Assistance with toilet use or incontinence care
- Intermediate services require some professional supervision but may be performed by properly trained non-professional personnel. The following illustrated services are generally considered to be of a supportive nature and are less intensive than skilled LOC services:
  - Administration of routine oral medications, eye drops, ointments, or any combinations of all of these
  - Injections that usually can be self-administered, such as the well-regulated diabetic who receives daily insulin injections. The administration of an occasional or PRN IM injection is appropriate for intermediate LOC.
  - General maintenance care of a colostomy or ileostomy, including cleaning the ostomy, changing ostomy bags, and routine use of equipment
  - Routine insertion and maintenance for patency of indwelling catheters
  - Dressing changes in non-infected post-operative or chronic conditions
  - Prophylactic and palliative skin care, including bathing and application of medical creams or treatment of minor skin conditions
  - Administration of O_2 after initial phases, for a stable, chronic condition
  - Routine care of plaster cast and brace patients, including hip spica or body casts
  - Administration of heat as a palliative treatment
  - Provision and supervision of restorative measures

  - Provision of skilled services or procedures when the resident's overall condition does not require the intensity of professional nursing services necessary for skilled LOC
  - Twenty-four-hour-a-day supervision or direct assistance to maintain safety due to confusion or disorientation that is not related to or a result of mental illness.
- IHCP does not reimburse for services below the intermediate LOC

Level-of-care Certification (Form 450B) Review

Instructions for completing information about *Form 450B* are as follows:

- Review the chart and circle **Y** if the Physician Certification for LTC Services (Form 450B) is present.
- If no LOC Certification is present, determine why this information is not on the resident's chart and circle **N**. Other acceptable documents are original certifications before July 1, 1976; and the *State Authorization and Data Entry* (SA/DE) form for admissions after October 1, 1998.

If **Y** was circled for the LOC certification, complete the **Effective Date**:

- Circle **Y** or **N** as appropriate for **Correct for current LOC**
- If the physician has signed requesting LOC certification, and it has not been returned by IFSSA, use the date on the copy of the LOC certification the physician signed to complete the **In Process** date.

Level-of-care Determination

If the documentation in the resident's medical record does not establish that the current LOC is appropriate, the audit team should recommend a transfer to the appropriate level-of-care by noting **SK**, **IC**, or **D/C** by the **Transfer** line on the audit worksheet.

Discharge recommendations should be made only after all documentation regarding the resident is considered. Some key information to review and confirm include:

- The admission date to institutionalization (not only the current NF, but any previous NF stay),
- Availability of community support (does the resident have family/friends available for care needs?),
- The resident's perception/feelings of institutionalization (has the resident expressed the desire to leave the NF and return home?), and
- The resident's current and past cognitive skills.

The audit team reviews all criteria listed in *405 IAC 1-3-2* to verify that the resident does not meet any of them. Prior to physician review, the EDS LTC supervisor and manager review discharge recommendations. The physician review process is noted later in this section.

Resident Observation

One of the most essential components of both the level-of-care and case mix review processes is resident observation review. The audit team member who has audited that resident's chart must complete the observation. **An EDS team registered nurse must see all Stage III or IV pressure or stasis ulcers.**

If the facility identifies a resident as currently hospitalized, the audit team must call the hospital to verify admission and continued stay. Hospitalization information is recorded on the audit worksheet.

If the resident is not available for observation, the auditor records that the resident was **not seen** on the audit worksheet. The audit team does not make a follow-up visit to observe the resident.

The audit team should plan on observing residents throughout the audit process. The audit team should use a completed worksheet as a means of comparison. The facility staff may be able to provide additional information if it is needed. If information on the form is not consistent with resident observations, discrepancies should be resolved, and documented on the audit worksheet. Resident observation should occur during mealtime, therapies, facility activities, or other times when the resident tends to be the most active or involved in activities related to the RUG-III classification. It is important for the auditor to note that resident observation should not be restricted to the conclusion of the medical record review portion of the audit.

Preparation for Exit Conference

Institution for Mental Disease Identification/Mental Illness Statistics Sheet

As part of its contractual obligation to the OMPP, the EDS LTC audit team reviews Level II information during the LOC and Case Mix audit. The audit team must confirm that Level II information has been completed for appropriate residents by reviewing Level II recommendations and ensuring that they are being provided. The audit team is also responsible for making referrals for residents who warrant further evaluation.

The audit team reviews 25 percent or a minimum of five residents, identified by the facility, who have a mental illness (MI) diagnosis confirmed by a Level II

evaluation. The audit team is responsible for ensuring that each resident identified on the Level II list has had a Level II evaluation, and that the results are on the resident's chart. This information is found in the chart review of the H & P, admission and current diagnoses, or current treatment charting that documents the MI treatment or specialized services. This information is documented on the audit worksheet.

At the completion of the on-site audit, the audit team completes the following information on the *Nursing Facility Audit Information* sheet: (this is also the worksheet name for the *IMD Identification/MI Statistics* sheet.)

- Total number of residents in the facility—obtain this information from the facility representative
- Number of residents with an active MI diagnosis verified by Level II evaluation, including residents with MI/MR diagnosis
- Number of residents currently recommended for specialized services from the Level II documentation. (Indiana defines specialized services as the need for psychiatric inpatient care.)
- Number of residents reviewed for a Level II Assessment, identified as residents demonstrating a significant change in condition from the previous Level II.
- Initials of auditor
- Facility name and provider number in *Level I Assurance* section of form

A facility that has 50 percent or greater population with a diagnosis of mental illness may be an Institution for Mental Disease (IMD). A secondary EDS audit team, including a physician, completes an on-site review to assess the patient population for placement needs relating to primary mental illness or medical needs.

If the secondary audit team concludes the facility is an IMD, a notification letter is forwarded to the facility. Reimbursement for IHCP services end with this determination.

The facility is required to generate a monthly list of all residents with the following information:

- Total number of residents on the first calendar day of the month
- List of all residents currently requiring specialized services for their mental disease
- List of all IHCP residents
- List of residents no longer requiring specialized services along with supportive documentation

The facility provides this information to the LTC unit and the unit supervisor reviews it.

If the facility MI population drops below 50 percent, the audit team verifies the facility's IMD status in another on-site visit. IHCP payments can be reinstated if the facility no longer qualifies as an IMD. Monthly monitoring of the facility continues until the next on-site review within 15 months.

For more information, refer to *Section 6, Facility Audit Information Sheet*.

Medicaid Audit Information

The *Medicaid Audit Information (MAI)* form is a summary of the audit that is completed by the audit team at the conclusion of the medical record review. As the auditors enter information on the MAI, they verify the accuracy of the numbers by counting the total number of worksheets in the packet. The information on the audit worksheets should be reflective of the information recorded on the Ad hoc Report, facility list, and MI Statistics Sheet.

The three main sections of the *MAI* form address the following components of the audit:

- Section A: General Facility Information
- Section B: Record Review Findings
- Section C: Case Mix Reimbursement Validation Summary

Section A: General Facility Information

The audit team records the date or dates of the audit and all identifying provider information including name, address, telephone number, and provider number. The names of the facility administrator and director of nursing are also recorded, and if either is new since the last audit, this is indicated with an **x**. Each auditor's signature and title is also recorded on the *MAI* form.

Section B: Record Review Findings

The EDS audit team verifies the census with the facility liaison and documents it on the *MAI* form. The number of residents audited, the greater of 40 percent of the census or 25 residents, is also recorded. Exceptions to this requirement are rosters with less than 25 residents and audits expanded due to an error rate greater than the threshold.

The audit team records the number of residents audited in each category of the sample in the following manner:

- Residents Audited – Number of residents audited as described in *Section B Record Review*
- Medicaid Total – Number of residents with RID number included in the audit sample
- Continued Care – Sum of D through I, minus Fi and ii.
- Hospitalized – Number of IHCP covered residents only
- Not Seen Residents – Number of IHCP covered residents only
- Resident Seen – Sum of the residents with no 450B or an *In Process* 450B
- Discharged –Number of IHCP residents recommended for discharge
- Discharge Referral – Number of IHCP residents referred to BDDS for evaluation
- Other – Total of all other residents in the sample not already addressed, including those pending IHCP eligibility

Level II Referrals –Number of residents recommended for a new Level II assessment

Resolved – Number of circled names from the Ad hoc Report. If there is no Ad hoc Report the auditor lists the disposition of the residents on the list and leaves this section blank on the *MAI* form.

Section C: Case Mix Reimbursement Validation Summary

The auditor records MDS case mix reimbursement statistics in the grid at the bottom of the *MAI* form. The number of records reviewed in each RUG-III category is recorded in the Records Reviewed column. The number of valid records for each RUG-III category is entered in the Valid Records column (the minimum number of responses used to classify the resident are fully supported). The Records in Error column reflects the number of records for which the audited value(s) does not support the RUG-III classification. After the findings for each RUG-III category are recorded, the numbers in each column are totaled and recorded at the bottom of the grid, and the audit team records the percentage of valid records. Dividing the number of valid records by the total number of records reviewed gives this percentage.

After the *MAI* form has been reviewed for completeness and accuracy, the audit team completes the *Exit Conference* form.

Interagency Referral Form

The LTC Unit supervisor will initiate an *Interagency Referral* form when an issue arises that should be referred to an interacting agency.

Such concerns or issues may include, but are not limited to:

- MDS issues
- Billing issues
- Health and Safety issues
- Medicare issues

Exit Conference Preliminary Findings Form

EXIT CONFERENCE PRELIMINARY FINDINGS

FACILITY_____

PROVIDER #_____

AUDIT DATE ____/____/____ **TO** ____/____/____

COPIES PROVIDED:

_____**PROVIDER SUMMARY**

_____**EXIT CONFERENCE PRELIMINARY FINDINGS**

_____ **SUPPORTIVE DOCUM. GUIDELINES (version 10/00)**

_____**OTHER:**_____

SPECIAL AREAS FOR DISCUSSION:

_____

_____

_____

EXPANDED AUDIT _____**YES** _____**NO**

PRELIMINARY VALID _____**%**

SIGN IN FOR EXIT CONFERENCE (PRINTED NAME, TITLE)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

PRELIMINARY STATISTICS REFLECT RECORDS TRANSMITTED THROUGH _____ (DATE OF M&S ROSTER).

RUG Category	Records Reviewed	Valid Records	Records in Error	Inaccurate Records
REHABILITATION				
EXTENSIVE SERVICES				
SPECIAL CARE				
CLINICALLY COMPLEX				
IMPAIRED COGNITION				
BEHAVIOR				
REDUCED PHYSICAL				
TOTAL				

I certify that the EDS auditors have been provided all the necessary medical documentation and/or other applicable records, in order to fully disclose the extent of services provided to facility residents.

Facility Staff Signature: _____ **Date: _____**

Printed Name and Title: _____

*** Preliminary Information**

Figure 2.8 – Exit Conference Preliminary Findings Form

The EDS audit team completes the *Exit Conference Preliminary Findings* form to prepare for the exit conference. The *Exit Conference Preliminary Findings* form is a high level summary of the audit findings and functions as an outline for the education the audit team provides at the exit conference.

The provider name, number, address, and telephone number are recorded on the *Exit Conference Preliminary Findings* form. The audit team records the dates of the audit and the date of the exit conference. The names of the EDS auditors are also recorded on the form.

The section entitled *Areas for Discussion* lists many of the problematic areas revealed through the audit process. This list is not comprehensive and education should not be limited to these issues. The audit team is responsible for providing education at the exit conference that addresses all areas where the facility needs to focus attention.

The *Exit Conference Preliminary Findings* form reflects **preliminary statistics** of the audit, based on the last records transmitted and found on the resident roster. The auditor must record the date of the resident roster from which they have been working on the *Exit Conference Preliminary Findings* form.

The grid at the bottom of the *Exit Conference Preliminary Findings* form duplicates the information on the *MAI* form. The auditor copies the data from the *MAI* form to the *Exit Conference Preliminary Findings* form. This information reports the accuracy of the chart documentation during the exit conference. The EDS auditors use the information contained in the grid to report the percentage of error.

At the bottom of the *Exit Conference Preliminary Findings form,* is a statement certifying that the audit team has addressed all issues indicated on the form and that the facility has provided all necessary documentation to disclose the extent of services provided to facility residents. The facility administrator or designee, must sign, including title, and date this certification statement.

The audit team is required to leave a copy of the completed *Exit Conference Preliminary Findings* form with the facility staff at the end of the exit conference.

Exit Conference

The audit team notifies the facility administrator that the audit is complete and requests that appropriate staff members be invited to attend the exit conference. At minimum, the administrator, director of nursing, and MDS coordinator should attend. The administrator, in cooperation with the audit team, should determine the time and location for the exit conference.

The audit team begins the exit conference by reintroducing themselves and thanking the facility staff for their cooperation during the audit.

All facility staff members attending the exit conference should **print** their names and titles on the sign in area of the *Exit Conference Preliminary Findings* form. The administrator or designee should sign all recipient lists and verify that the facility representative has signed the *MI Statistics sheet*.

During the conference the audit team presents information about the number of records reviewed in the categories listed on the *MAI* form. The audit team also confirms the facility census information provided earlier in the audit and explains that the results and validation rates presented during the exit conference are preliminary results, and that final results will be sent later.

The audit team gives an overview of the requirements and process for *Form 450B* submission and reminds the facility staff that all *Form 450B* instructions are detailed in the bulletin entitled Indiana Health Coverage Programs Update *BT200002* published April, 5, 2000. *Form 450B SA/DE* is also covered at this time to familiarize the staff with the form's purpose and the address from which a supply may be ordered. If an approved *Form 450B* or *450B SA/DE* could not be located for a resident, the audit team explains that the facility cannot bill or receive payment from the IHCP for that resident.

The audit team reviews the Level I and Level II assessment process and explains that although the Level I form is no longer required annually, it is required for each resident on admission to the facility. The Level I form must be updated, as needed, to ensure that it accurately reflects the condition of the resident. Level II assessments are required for all residents with a diagnosis of mental illness and/or mental retardation or developmental disability. Like the Level I assessment, Level II assessments are not required annually; however, the facility is obligated to make a Level II referral if there is a significant change in the condition of a resident. This requirement is described in the bulletin Indiana Health Coverage Programs Update *E97-21*. Residents who do not have timely Level II assessments or for whom clarification in status is needed are recommended for Level II referrals. A letter outlining the audit findings is sent within 10 business days of the audit completion and includes the names of residents recommended for Level II referrals. Instructions for the referral process are contained in this letter. The facility is obligated to follow all recommendations specified in the Level II assessment, not only to ensure that resident needs are being met, but also because it is a provision of the IHCP provider certification. The facility administrator must complete and sign the *MI Statistics sheet* if it has not already been done.

A large part of the exit conference provides education about the case mix system of reimbursement audit requirements. The audit team thoroughly reviews the RUG III classifications and findings for each category. The exit conference is an ideal opportunity to assess the facility staff's comprehension of

the RUG III classification process and requirements. It is important to allow as much time as needed in the exit conference for staff to ask questions and obtain clarification from the audit team.

The audit team is encouraged to begin the discussion of Case Mix and RUG-III audit findings by providing an overview of *405 IAC 1-14.6* and *405 IAC 1-15*. If the facility is unaware of these rules, the audit team should provide the rule and allow the staff to make a copy.

The audit team addresses the four ADLs that influence each of the 44 RUG-III classifications. They are identified as follows: bed mobility, transfer, toilet use, and eating. For the first three of these ADLs, the facility must document both resident self-performance and staff support provided. Only resident self-performance is assessed for eating.

The seven RUG-III categories and a brief explanation of their components along with the audit statistics for each of the categories is presented. The number of records reviewed, the number of records in error for each RUG-III category, and the overall preliminary error rate for the facility are also reported at this time. The audit team indicates the reasons the records were in error, such as insufficient ADL documentation or other elements that could not be validated with the supportive documentation provided to the audit team.

At this time, the audit team also advises the facility staff of other types of deficiencies and areas of concern. Examples of potential reasons for record error are indicated in the following table.

Table 2.16 – Deficiencies and Areas of Concern for Record Errors

Areas of Concern	Potential Reasons for Record Errors
Nursing restorative programs must meet all of the requirements in the RAI Manual, including documentation in minutes.	The documentation in the resident's medical record did not include minutes or the appropriate number of days to support the response coded on the MDS.
The IHCP case mix system of reimbursement requires that all therapies be documented to support actual minutes of therapy provided by modality for the Special Rehabilitation RUG-III category.	The records reviewed did not provide supportive documentation for actual minutes of therapy provided. The documentation for therapies was in units rather than minutes.
Certain data elements on the MDS require that a physician's diagnosis be documented in the resident's medical record to qualify for the Special Care or Clinically Complex RUG-III categories.	The medical record documentation reviewed did not contain the appropriate diagnosis information to support the response that was coded on the MDS.

(Continued)

Table 2.16 – Deficiencies and Areas of Concern for Record Errors

Areas of Concern	Potential Reasons for Record Errors
All items coded on the MDS that impact the depression scale component of the Clinically Complex RUG-III category require documentation describing the areas addressed on the MDS.	The medical records reviewed did not contain documentation that describes the resident's condition as presented in the *Supportive Documentation Guidelines*.
To meet the criteria for the Impaired Cognition RUG-III category, the medical record must contain documentation citing examples of the resident's cognitive status. Examples should be provided in the documentation to substantiate the resident's short-term memory, recall ability, and decision-making skills. The audit team should review the medical record documentation for evidence of items the resident was not able to recall. With regard to recall ability, this is one of only three areas for which the audit team must find supportive documentation to indicate what the resident is unable to do rather than what the resident is able to do.	The medical record did not contain specific examples of the resident's cognitive ability.
Data elements coded on the MDS that group to the Behavior RUG-III category must be substantiated with documentation citing specific examples of the behavior displayed by the resident.	The medical record review did not reveal examples of the resident's behavior to support the response coded on the MDS.
For MDS purposes, the RAI Manual requires that pressure ulcers must be down-staged. For example, a Stage IV pressure ulcer that was first documented as Stage IV, and is now Stage II, must be coded on the MDS as a Stage II.	The documentation in the medical record indicated that the pressure ulcer was a Stage IV healing.
The intent of the P8 data element on the MDS is to reflect the number of days during the last 14-day period a physician has changed a resident's orders. For example, five new orders in one day are counted as one day for coding the MDS. The key point for this data element is the **number of days** in which there was a change in orders, rather than the actual number of orders that were changed.	

End of Therapy Requirement

Significant Change Correction

The *RAI Manual* defines Significant Change as a major change in the resident's status that:

- Is not self-limiting
- Impacts more than one area of the resident's health status

- Requires interdisciplinary review and/or revision of the care plan

It is the facility's responsibility to assess the resident's status, and complete a significant change assessment if a decline or improvement is consistently noted in two or more areas. Refer to the table entitled *Significant Change Criteria*, in the *RAI Manual*, page 3-37.

Validation Improvement Plan

All facilities that exceed the error threshold are required to submit a Validation Improvement Plan (VIP). The initial validation threshold of 50 percent decreases in increments of 15 percent over three 15-month periods allowing IHCP-certified nursing facilities to have at least one audit as the corrective remedies are being phased in. This VIP is forwarded to the facility along with the final audit summary, and those audit worksheets found to be in error. EDS has 10 business days from the last date of the on-site audit to forward this information to the facility. The facility has 15 business days, from the letter's issue date, to respond to areas of deficiency with a written VIP addressing the issues identified in the audit summary letter. Table 2.17 provides validation threshold information.

Table 2.17 – VIP Threshold and Corrective Remedy Percent

Effective Date	Threshold Percent	Administrative Component Corrective Remedy Percent
October 1, 1999	50 percent	5 percent
January 1, 2001	35 percent	10 percent
April 1, 2002	20 percent	15 percent

Additional Topics for Discussion in the Exit Conference

During the exit conference, the audit team discusses the re-audit process. All facilities found to exceed the error threshold may be re-audited. Subsequent, consecutive visits in which the facility exceeds the error threshold, may result in the termination of the IHCP provider agreement and reimbursement by the OMPP. Additional information about this topic is found in the *Re-Audit Procedure* later in this section.

An additional letter may be sent to the facility that includes any Level II referrals and discharge recommendations made because of the audit. This letter contains instructions for making Level II referrals along with information regarding discharge recommendations. If a resident has been recommended for discharge from IHCP reimbursement as a result of the audit, a separate letter outlining the recommendation and explaining the appeal process is addressed to

that recipient. The facility is responsible for directing the letter to the resident or the resident's power of attorney or legal guardian.

The auditors conclude the exit conference by having the administrator or facility designee sign, title, and date the *Exit Conference* form.

Post Audit Procedures (On-site)

Notice of Misuse or Failure to Comply with IHCP Policy (Postpayment Review)

When the audit team identifies unusual circumstances that may require further review by the medical policy contractor Health Care Excel (HCE), such as fraud or abuse, a *Postpayment Review Referral* form is written by the team and forwarded to the LTC Unit supervisor. The following process is followed when suspect information or circumstances are found that do not appear to adhere to IHCP policy or appropriate billing guidelines:

- One or both EDS audit team members complete the *Postpayment Review Referral* form giving pertinent information related to the possible misutilization or policy issue found during the on-site review (See *Postpayment Review Referral* form in *Section 6: Forms*).
- The audit team copies pertinent documentation related to the referral.
- The *Postpayment Review Referral* form and accompanying documentation are turned in with the audit packet.
- The LTC Unit office coordinator forwards *Postpayment Review Referral* form information to the LTC Unit supervisor, after the packet is received and reviewed in the office.

The LTC Unit supervisor and the LTC Unit manager review the referral and documentation and complete the following steps:

- Copy the *Postpayment Review Referral* form and documentation, and keep one copy in the LTC Unit file and another copy in the facility file.
- Forward all originals to HCE. For cases of misutilization or questionable billing practices, the information is directed to the HCE Surveillance and Utilization Review (SUR) Unit. For cases of questionable medical policy or prior authorization issues or concerns, the documentation is forwarded to the HCE Medical Policy Unit. All information is forwarded to HCE by courier.
- Document the date of referral on the information maintained in the LTC Unit files.

Referral to EDS Client Services

Audit team members make every effort to answer provider questions and concerns. For areas the auditor is not familiar with, the facility should be instructed to contact their provider representative or the EDS Client Services Unit.

One of the auditors should also complete a *Memorandum* form (See *Section 6, Memorandum*), giving the facility name, provider number, date of on-site visit, and question. The EDS office coordinator forwards the form to the Client Services Unit on packet review, and a copy of the memo is kept in the facility file.

General Information Notification

Issues that raise questions should be forwarded to the LTC Unit supervisor and/or manager on the *Memorandum* form (See *Section 6, Memorandum*).

Post Audit Procedures (in Office)

Audit Packet Review

The audit team is responsible for verifying that the audit packet is complete and accurate. The LTC statistical analyst records the audit information on the Quarterly Report.

Nursing Facility Postreview Checklist

The audit team completes the *Nursing Facility Postreview Check List* entirely and transfers information from the MAI Record Review section to the corresponding area of the checklist. All audit team members must initial the form in the designated area. The packet must be organized in the order designated on the checklist.

Quarterly Report

The final step of audit packet completion is recording audit information for Quarterly Report completion. The LTC statistical analyst enters necessary information in the *blue book*, (the blue binder holding the current report). The report lists all IHCP-certified nursing facilities in Indiana with their addresses and provider numbers. The report also includes ISDH changes received concerning the provider's certification, ownership, or address as well as the three most current audit dates for the facilities along with the audit team names and titles.

Audit Summary Information

Level-of-care and Level II Referral Letter

The LTC review's purpose is to determine compliance with Indiana case mix reimbursement requirements, to evaluate service provision directed by Level II assessments according to PASRR regulations, and to ensure that IHCP recipients continue to **meet** the minimum level of service for facility placement.

The LTC Unit notifies the facility in writing of audit findings within 10 business days of the audit date. The letter addresses the recommendations from the on-site review in the following format:

- *MI & MR/DD Residents Identified*—Lists the names of all residents who require further evaluation and must be referred by the facility for a Level II assessment. The letter gives instructions about making Level II referrals. Copies of those residents' audit worksheets are included.
- *Recommended Discharges*—Identifies IHCP recipient(s) for whom the audit team has recommended discharge because of a failure to meet minimum facility level-of-care. A separately addressed letter to the recipient(s) is included with the facility letter. *Forms 1702* and *1703* are sent to the facility along with instructions for completion by the resident or resident's guardian. Appeals may only be filed by the resident or resident's guardian.
- *MI & MR/DD Identified Persons Referred with Recommendation to Discontinue*—Identifies PASRR-related IHCP residents who have been recommended for discharge and referred for review and final determination to BDDS because the resident has no medical level-of-care for continued facility placement. These are the only cases in which BDDS makes the final discharge determination, thus no action is required by the facility or resident at this time. BDDS notifies the resident and facility if discharge is deemed appropriate. Facility and recipient appeal rights are given at that time.

Please reference *Nursing Facility Letter #1* in *Section 6: Forms* for an example of this letter.

Case Mix Summary of Findings Letter

The LTC unit has 10 business days from the last date of the audit to review the packet for completeness and issue a summary of findings letter addressing only those records found to be in error. This letter, sent to the facility administrator, reviews the implementation date for the Case Mix Reimbursement System, and indicates resident classification based on responses from the MDS assessment. It further clarifies facility payments based on one of 44 RUG categories. Patterns and trends that have been identified are also discussed in the letter. Please review *Section 6, Provider Summary Preliminary Findings worksheet*.

A VIP and individual audit worksheets, supplement the summary of findings letter, if any areas of deficiency in the facility were noted.

Reconsideration Request

Audit findings are forwarded to Myers & Stauffer for reclassification. Any changes in Case Mix Index (CMI) or the corresponding rate are communicated to the facility through Myers & Stauffer

A copy of the *Summary of Findings letter* is sent to the OMPP and the ISDH.

Validation Improvement Plan

A Validation Improvement Plan (VIP) is required from all facilities with an error rate in excess of the threshold set forth in *405 IAC 1-14.6*.

VIPs and the suggested format are sent to the facility with the audit findings within 10 business days of the last audit. The facility has 15 business days to complete and forward the VIP to the LTC unit. The following elements are required:

- Audit exit date
- Valid record percentage
- Areas requiring improvement
- Facility remedy
- Completion date
- Person responsible (required for each corrective action step)
- Administrator or designee signature
- Date signed

Section 6: Forms includes an example of a VIP.

The facility mails the VIP to the LTC hearing and appeals analyst who reviews it for completeness. The VIP is filed in the facility's file to be available when the facility is audited next. The auditor uses the VIP on file to verify that corrective actions have been taken.

Physician Review

Any auditor recommendations for discharge are forwarded to the physician consultant for review. The physician makes a determination based on medical

expertise and rules found in *405 IAC 1-3-1* and *405 IAC 1-3-2***,** and documents the findings on the audit worksheets. The physician must sign and date the worksheets and forward them to the LTC unit supervisor.

If the physician disagrees with the discharge recommendations, the audit worksheets are returned to the facility file and the MAI is modified to reflect the resident's continued care status.

If the physician agrees with the discharge recommendation, the audit worksheets and any pertinent information are forwarded to the OMPP for further review and recommendation. A letter is sent to the facility and the resident within 10 business days from the last date of the audit stating that a discharge recommendation has been made.

Re-Audit Procedure

The LTC unit may re-audit nursing facilities determined to equal or exceed error threshold. Facility notification must be given prior to re-audit no more than 72 hours before the audit.

When possible, at least one member of the original LTC audit team should perform the subsequent audit. If the second audit exceeds the error threshold, the following steps are taken.

1. The LTC Unit sends a request for a VIP with the final audit findings.
2. The LTC Unit notifies the OMPP of the audit findings.
3. At the direction of the OMPP, the LTC Unit sends a letter to the facility emphasizing that the IHCP provider agreement could be in jeopardy if the facility continues to exceed the error threshold.
4. The LTC Unit sends a letter to the ISDH, emphasizing the OMPP's concern with the facility.
5. The LTC Unit schedules a re-audit within six months of the second audit.
6. If the third consecutive audit exceeds the error threshold, the facility is referred to the OMPP that could terminate the facility's IHCP provider agreement.
7. The LTC Unit sends a letter to the facility addressing any consequences that must be applied.

If the facility's IHCP provider agreement is terminated, the facility no longer receives reimbursement for IHCP services. This termination remains in effect until the provider requests a reconsideration of its IHCP provider agreement status from the OMPP. On receipt of the reconsideration request, the LTC unit

schedules and conducts another audit. If the audit indicates an error rate that is less than the threshold, the facility's provider agreement may be reinstated.

Referral to Outside Agencies

Level II Referrals to CMHC, BDDS, and ISDH

EDS is responsible for reviewing facility compliance with recommendations made on Level II assessments. For residents with Level II assessments indicating mental illness or mental retardation/developmental disability, the audit team records the recommended services and reviews the chart for documentation that supports service provision. Requests are made to facility staff for supportive documentation if the team is unable to find it in the chart. When the audit team cannot verify compliance with Level II recommendations, a memo to the LTC Unit supervisor is completed which generates a letter to the ISDH indicating PASRR noncompliance. The letter is carbon copied to the appropriate Community Mental Health Center (CMHC) or the Bureau of Developmental Disabilities Services (BDDS) depending on the recipient's diagnosis.

Table 2.18 illustrates the noncompliance events that may be found during the Level II review process, and the resulting letters:

Table 2.18 – Noncompliance Events and Letters

Noncompliance Noted	Letters Sent To:
Resident has a confirmed MI diagnosis but recommended Level II services are not provided	• *Local CMHC* • *ISDH* • *Cc: Nursing Facility*
Resident does not have a confirmed MI diagnosis but past or current information supports a possible major mental health condition	• *Local CMHC* • *Cc: Nursing Facility*
Resident has a confirmed MR/DD diagnosis but recommended Level II services are <u>not</u> provided	• *Local BDDS office* • *ISDH* • *Cc: Nursing Facility*
Resident has a MR/DD diagnosis but current medical status appears to take precedence over their active treatment needs.	• *Local BDDS office* • *Cc: Nursing Facility*
Resident does not have a confirmed MR/DD diagnosis but past or current documentation supports a possible MR/DD diagnosis	• *Local BDDS office* • *Cc: Nursing Facility*

Safety Concern Referrals to the ISDH and/or Adult Protective Services

After the on-site review, the LTC audit team documents concerns about the safety and well-being of any institutionalized resident using the *Memorandum* form. Additionally, the LTC audit team telephones the LTC supervisor and follows up with a memo documenting the information. The LTC supervisor sends a letter of concern to the ISDH or the Adult Protective Services (APS) Office, depending on the situation. If the LTC audit team recommends immediate resolution, the LTC supervisor telephones the appropriate agency to relay the information. All correspondence is placed in the LTC Unit file, the facility's file, and a copy is sent to the OMPP.

MDS/RAI Referral to State Department of Health and/or Medicare Fiscal Intermediary

Table 2.19 illustrates the MDS review audit findings and resulting letters to the ISDH:

Table 2.19 – Audit Findings and Letter to ISDH

Audit Findings	Letter to the ISDH
All nursing facility audit findings with MDS, LOC and PASRR information from the routine on-site audit	A copy of the letter generated back to the NF with MDS audit, LOC, and PASRR information
All nursing facility audit findings with >/= error threshold from the first on-site audit	An informational letter outlining the >/= error threshold findings
All nursing facility audit findings with >/= error threshold rate (specific to the date of the audit) from the second consecutive on-site visit	On behalf of the OMPP, a letter emphasizing the OMPP's concern with this NF
All nursing facility audit findings with >/= error threshold rate (specific to the date of the audit) from the third consecutive on-site audit	On behalf of the OMPP, a copy of the letter forwarded to the NF regarding any consequences that may be applied, and an additional informational letter regarding the consistent noncompliance exhibited by the NF, in regard to MDS information transmission

If the LTC auditor is unsure to which agency a referral should be directed, the LTC supervisor can provide direction via telephone. The audit team should follow up with a completed *Memorandum* form to the LTC supervisor, which outlines concerns and gives pertinent details.

Section 3: Hoosier Healthwise Considerations

General Information

IHCP covered NF services are not included in the Hoosier Healthwise Managed Care Program. Members are **disenrolled** from their Hoosier Healthwise managed care network at the time they become eligible for long-term care or NF services and **their coverage continues under the fee-for-service Traditional Medicaid program.**

PrimeStep PCCM

Members who are assigned to a primary medical provider (PMP) in the PrimeStep PCCM network of Hoosier Healthwise are disenrolled from the Hoosier Healthwise network once LOC has been approved. The PMP is not responsible for certification of NF services.

Risk-Based Managed Care

The following narratives describe the Managed Care Organization's (MCO) responsibilities for their enrolled members in the Risk-Based Managed Care (RBMC) network of Hoosier Healthwise when LTC services are necessary.

Short-Term Nursing Facility Placement

While LTC services are not covered in the Hoosier Healthwise Managed Care Program, an MCO can place their enrollees in a NF setting on a short-term basis if this setting is cost effective and the member can obtain the care and services needed. Members who require long-term care or whose short-term placement becomes a long-term placement are disenrolled from Hoosier Healthwise and coverage continues under the Traditional Medicaid portion of the IHCP:

- The MCO is financially responsible for reimbursing the NF at the IHCP fee-for-service rate or a rate negotiated with the facility for the short-term placement.
- In cases where short-term stay is extended, the screening must be completed within 25 days after the end of the short-term stay, except as specified for PASRR cases.

- If the member is determined to require long-term NF placement, the member is disenrolled from Hoosier Healthwise and converted to fee-for-service Traditional Medicaid.

The financial responsibility of the MCO is for the following periods:

- If the member's enrollment termination from Hoosier Healthwise is processed before the 26th day of the month, the effective date of the enrollment termination is the first day of the following month. The MCO is financially responsible for placement up to the end of the month in which the enrollment termination is entered into the system, for instance, if enrollment termination is entered February 25th, enrollment termination is effective March 1st; the MCO is financially responsible through February 28th.
- If the member's enrollment termination from Hoosier Healthwise is processed on or after the 26th day of the month, the enrollment termination becomes effective the first day of the second month after the enrollment termination is entered. The MCO is financially responsible for the placement the remainder of the month in which enrollment termination is entered and for the following month. For instance, if the enrollment termination is processed February 26th or after, the enrollment termination is effective April 1st; the MCO is financially responsible through March 31st.

Long-Term Nursing Facility Placement

Members in NF for LTC are disenrolled from the RBMC network of Hoosier Healthwise and their coverage continues under the Traditional Medicaid portion of IHCP. LTC services are not included in the scope of benefits provided to members in the managed care program. These services remain the responsibility of IHCP fee-for-service.

NFs and Area Agencies on Aging (AAAs) must notify the MCO immediately when an MCO member who is in a NF undergoes the IPAS/PASRR. After notification, the MCO initiates the enrollment termination process effective at the end of the month.

The MCO is financially responsible for all ancillary and professional services, including hospital care, provided to members until enrollment termination is effective. IHCP fee-for-service is financially responsible for LTC reimbursement if the member is approved for intermediate LOC, skilled LOC or general case mix per **405 IAC 1-3-1** and **405 IAC 1-3-2**.

NF coordinate with the MCO to allow members to use appropriate in-network services during the period when the member is assigned to the

MCO. Information about the specific MCO network in which a member is enrolled is available through the Eligibility Verification System (EVS).

*Section 4: Indiana*AIM *for Long Term Care Users*

Indiana*AIM* Logon

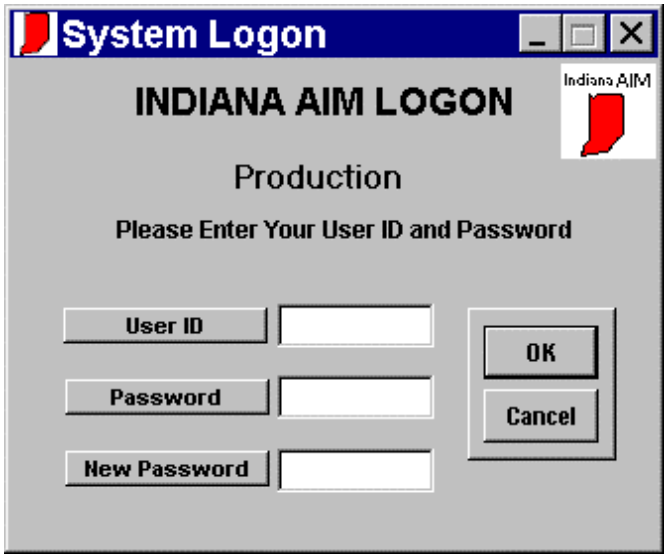


Figure 4.1 – IndianaAIM Logon Window

To access Indiana*AIM*, follow these steps:

1. Type the User ID supplied by EDS Security.
2. Tab to password and type the password supplied by EDS Security or the password to which the user has subsequently changed.
3. Press **Enter** or click **OK**.

Menu Bar

The menu bar is below the window's title bar and contains the headings for the list of commands or window options. The list of available options appears in a drop-down list box. If some options appear gray, they are not available at the time.

A window option is selected in the following manner:

1. Click the window option title.
2. Click the desired option title and a drop down box appears. Click the command or press **Alt+** the underscored letter of the desired option.

Menu Selections **File**, **Edit**, and **Applications** have the same functions on all the windows described in this section.

Menu Selection: File

This command provides the following options.

Exit Indiana*AIM* – Exits the user out of Indiana*AIM*

Menu Selection: Applications

This menu options accesses to all the functional areas in Indiana*AIM*.

Main Menu

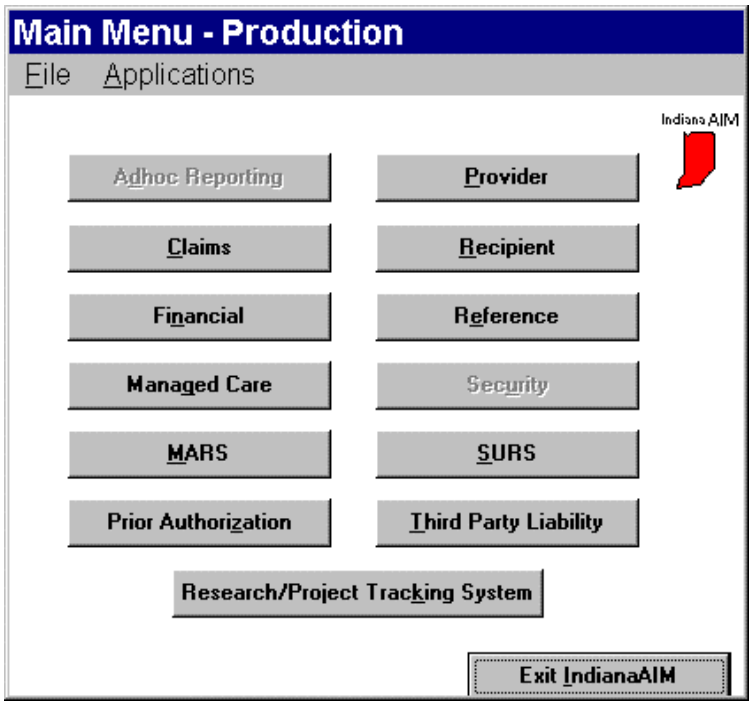


Figure 4.2 – Indiana*AIM* Main Menu

The main menu allows access to the subsystems shown in bold. User access depends on the security profile. LTC users can access the following areas of Indiana*AIM*.

- Claims
- Provider

- Recipient
- Reference
- Research/Project Tracking System

Claims Menu

The claims menu is the initial window opened after clicking **Claims** on the Main Menu. This window accesses the windows shown in Figure 4.3

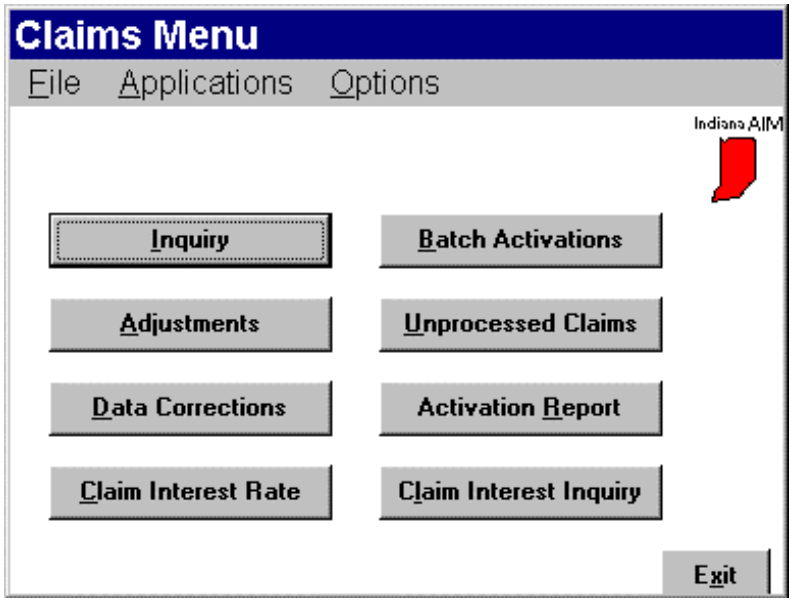


Figure 4.3 – Claims Menu Window

Claim Inquiry

The Claim Inquiry window is the primary window for accessing basic claims information. Various selection options narrow the claims selection options.

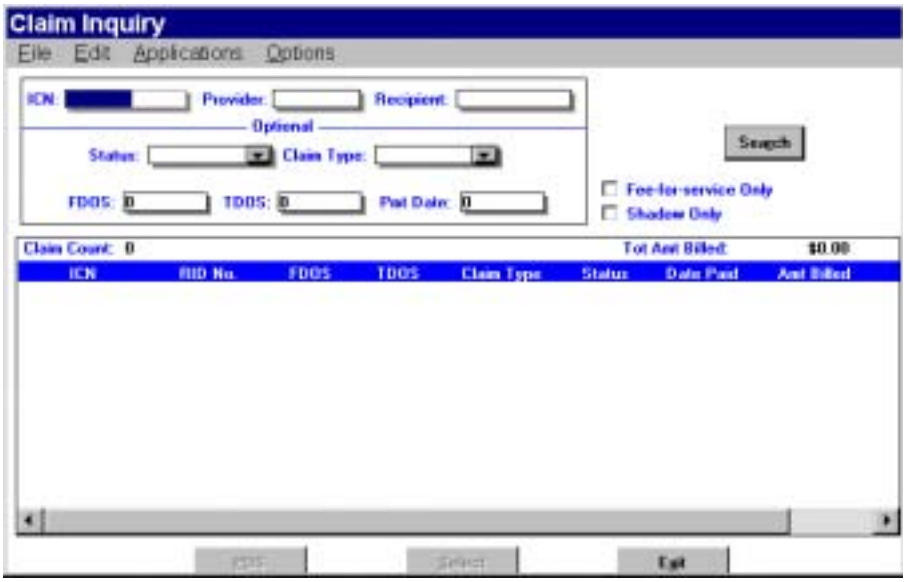


Figure 4.4 – Claim Inquiry Window

Primary selection criteria are Internal Control Number (ICN), provider number, or recipient number. One or all of these items may be selected as the criteria. Additional selection criteria include Claim Type, Claim Status, FDOS (from date of service), TDOS (to date of service), and Pmt Date (payment date).

The lower data window displays all claims that meet the criteria specified by the user. More specific ICN information can be accessed from this lower data window by double-clicking the appropriate ICN.

Provider Menu

The Provider Menu is the initial window opened after clicking **Provider** on the Main Menu.

Figure 4.5 – Provider Menu

LTC users can access Billing Services, Enrollment Tracking, Maintenance, and Software Company windows from the Provider Menu window.

Provider Search

IFSSA and EDS use the Provider Search window to access provider records using flexible selection criteria. Access this window by clicking **Maintenance** on the Provider Menu.

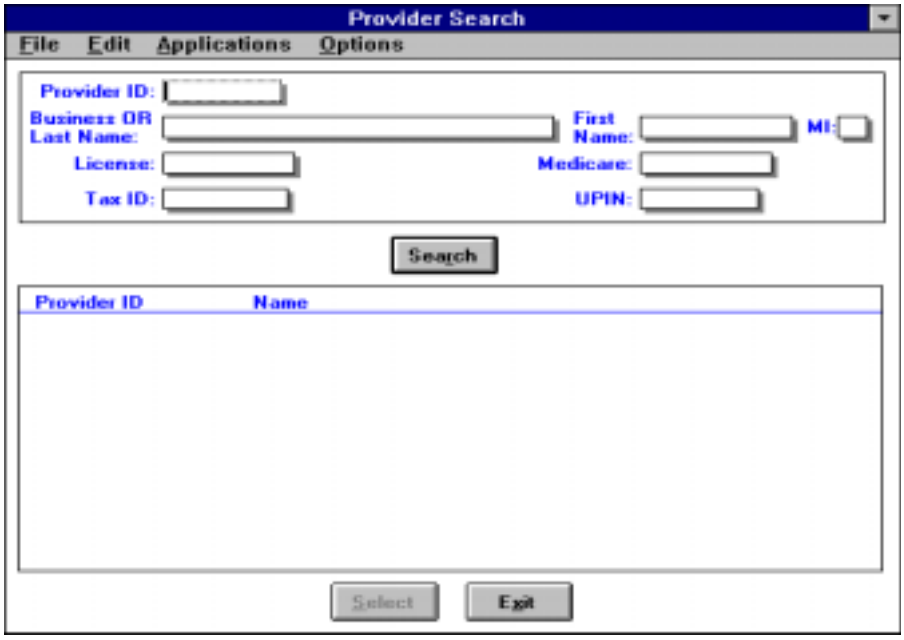


Figure 4.6 – Provider Search Window

Provider records can be selected by entering the desired Provider ID, UPIN (universal provider identification number), Tax ID (SSN/FEIN), Provider Name, Business OR Last Name, License, or Medicare numbers.

Provider Service Location

The Provider Service Location window views or updates provider information pertaining to a specific service location and accesses other screens with service location specific information.

Access this window by selecting **Service Location** through the Provider **Options** drop-down list.

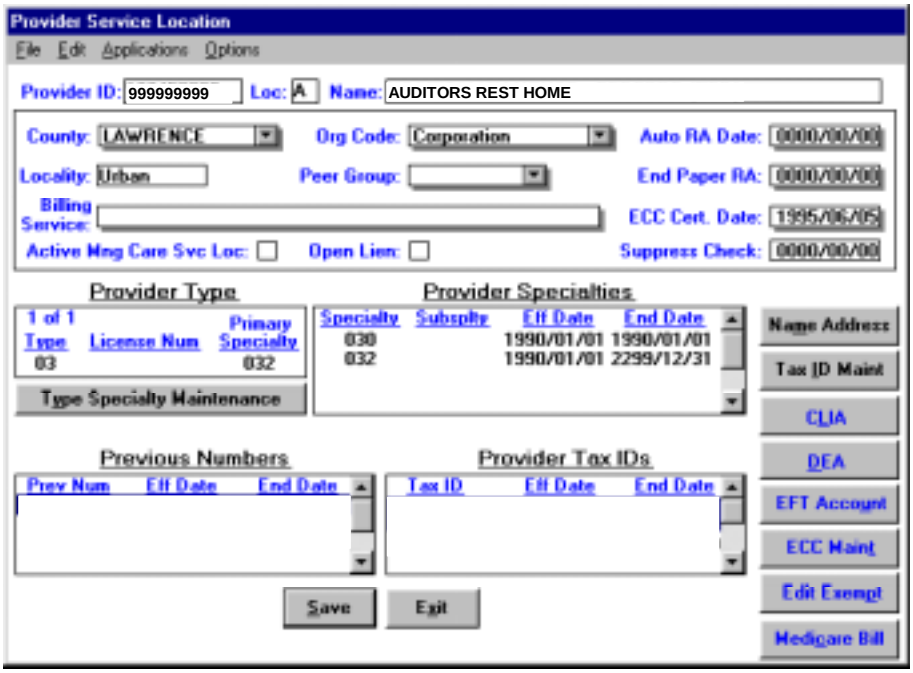


Figure 4.7 – Provider Service Location Window

Other significant information on the Provider Service Location window includes the following:

- **Locality** indicates the provider's geographic region according to county location.
- **Billing Service** is the name of the billing service used by the provider (if applicable).
- **Active Mng Care Service Location** indicates if the displayed service location is an active managed care service location.
- **Peer Group** is the provider's peer group according to geographic location or type of facility.
- **Specialty** is the provider's scope of practice.

Provider Address

The Provider Address window views or updates provider names and addresses for selected use. The window displays the list of names and addresses for a specific service location.

The Provider Address window is accessed by selecting **Name Address** from the Provider Service Location window.

Figure 4.8 – Provider Address Window

Change a name or address by selecting **Change Name** or **Change Address**. A new address may be added to the service location by selecting **New**.

Type of addresses for **Usage** includes the following: Home Office, Mail to, Pay To, and Service Location.

Section 5: Long Term Care Report Definitions

Report Definition: Monthly Composite Report for Nursing Facilities – LOC/PASRR

Report Number

LTC-0001-M

Description of Information on the Report

This is a manually-generated report listing each facility scheduled for on-site review during the report month. The nursing facilities are listed by provider name, in ascending alphabetical order, city, and provider number.

The report will document:

- Total number of facility residents audited.
- Total number of IHCP residents audited.
- Total number of IHCP residents recommended for continued care.
- Total number of IHCP residents in the hospital.
- Total number of IHCP residents not seen.
- Total number of IHCP residents that have no level-of-care certification present (Form 450B) or the level-of-care certification is in process.
- Total number of IHCP residents that are recommended for discharge.
- Total number of IHCP residents with MI/MR/DD diagnosis that are referred to BDDS for final determination.
- Total number of non-IHCP residents audited.
- Total number of Level II MI/MR referrals from all payer sources.

The information is obtained from each on-site LTC review *Medicaid Audit Information (MAI)* form and is reviewed by the LTC statistical analyst during the audit packet review done weekly.

The report will be entered into a Microsoft Excel document and printed on-line.

Purpose of Report

To document the on-site review statistics from each facility reviewed during the month reported. The report is generated and distributed to the OMPP by the 20th business day of the following month.

Report Definition: Quarterly Report – Facility Listing for Nursing Facilities

Report Number

LTC-0001-Q

Description of Information on the Report

This is a manually generated report listing each facility by provider name, address, and provider number in ascending alphabetical order. The report delineates the date(s) the audit was performed and the registered nurse completing the audit. The report also encompasses provider amendments which include certification addition or deletion, voluntary withdrawal and address, name and/or provider number changes.

The report is manually updated and revisions are entered into the Microsoft Excel document. The report is then printed online.

Purpose of Report

To document all nursing facilities who have participated in Medicaid anytime during the 15-month period ending on the last day of the quarter, all provider amendments, the last three on-site audit dates and the registered nurse that conducted reviews

Report Definition: Weekly Report of Facilities Audited

Report Number

LTC-0001-W

Description of Information on the Report

This is a manually generated report listing the facility name, date(s) of audit, percentage valid, and comments. The total number of facilities audited for the week and the overall average validation rate is indicated. The report is primarily sorted by percentage valid and secondarily sorted by facility name in descending order.

The information is obtained from each on-site LTC review *Medicaid Audit Information (MAI)* form and is reviewed by the LTC staff member during the audit packet review done weekly. The information is entered onto the monthly Microsoft Excel report and then printed online.

Purpose of Report

To document on-site statistics from each nursing facility reviewed during the week.

Report Definition: Monthly LTC Case Mix Validation and Error Report

Report Number

LTC-0002-M

Description of Information on the Report

This is a manually generated report listing each facility by provider name, city, and provider number in ascending alphabetical order. The report lists the total number of records reviewed, the number of valid records, the percentage of valid records, the number of erred records and the percentage of erred records.

The information is obtained from each on-site LTC review *Medicaid Audit Information (MAI)* form and is reviewed by the LTC staff member during the audit packet review done weekly. The information is entered onto the monthly Microsoft Excel report and then printed online.

Purpose of Report

To document on-site statistics from each facility reviewed during the month reported. The report is generated and distributed to the OMPP by the 20th business day of the following month.

Report Definition: Monthly Reconsideration Tracking Form

Report Number

LTC-0008-M

Description of Information on the Report

This is a manually generated report listing the facility name, provider number, date(s) of audit and initial validation percentage. Additional information indicates the date a request for reconsideration was received by EDS and the number of records that are to be reconsidered. The report also tracks the date EDS replies to the reconsideration, the number of records that were changed and the final validation percentage. The report is a chronological record of nursing facilities that request informal reconsideration of the preliminary audit findings.

The information is obtained from a facility that submits an informal written reconsideration request within 15 business days from the receipt of the written preliminary audit findings. The LTC Hearings and Appeals nurse reviews the request and renders a final response.

The information is entered into a Microsoft Excel report and then printed online.

Purpose of Report

To document all requests for informal reconsideration from nursing facilities. The report is generated in-house upon receipt of an informal reconsideration.

Report Definition: Monthly Comprehensive Case Mix Resource Utilization Group (RUG) Report

Report Number

LTC-0003-M

Description of Information on the Report

This is a manually generated report listing the number of nursing facilities audited during the month, number of records reviewed, number of fully supported records, percentage of records fully supported (valid records), and the cumulative number of facilities audited to date. The report will document the statistics by RUG classification including the RUG category, the number of records fully supported, and the valid percentage. The report lists statistics for each month in the 15-month time frame associated with the current error threshold policy.

The information is obtained from each on-site LTC review *Medicaid Audit Information (MAI)* form and is reviewed by the LTC statistical analyst during the audit packet review done weekly. The monthly report is a cumulative total of all facility MAI's completed during the month. The information is then entered onto the monthly Microsoft Excel report and printed online.

Purpose of Report

To document on-site statistics from each facility reviewed during the month reported. The report is generated and distributed to the OMPP by the 20th business day of the following month.

Report Definition: Monthly LTC Validation Improvement Plan Tracking Report

Report Number

LTC-0007-M

Description of Information on the Report

This is a manually generated report listing the facility name, provider number, date(s) of audit and validation percentage. Additional

information indicates if a follow-up audit is required and the original auditors. Tracking columns include the date EDS sent the original letter requesting completion of the Validation Improvement Plan (VIP), the last date the VIP may be submitted to EDS, and the date EDS received the VIP. The report is a chronological record of nursing facilities that did not meet the validation threshold.

The information is obtained from each on-site LTC review *Medicaid Audit Information (MAI)* form and is reviewed by the LTC staff member during the audit packet review done weekly. The information is entered onto the monthly Microsoft Excel report and then printed online.

Purpose of Report

To document all VIPs requested by EDS to nursing facilities and track due dates. The report is generated upon receipt of a VIP and sent to the OMPP quarterly, if necessary.

Report Definition: Monthly Synoptic Case Mix Statistics Report

Report Number

LTC-0004-M

Description of Information on the Report

This is a manually generated report listing the number of nursing facilities audited during the month, number of records audited, number and percentage of valid records, number and percentage of erred records. The report also documents the total number of residents audited, the number of delinquent records, and the number of records audited for End of Therapy. The report documents statistics by RUG classification including the RUG category, the number of valid and not valid records, and the valid percentage.

The information is obtained from the monthly Comprehensive Case Mix Resource Utilization Group (RUG) Report. The information is then entered onto the monthly Microsoft Excel report and printed online.

Purpose of Report

To document on-site statistics from each facility reviewed during the month reported. The report is generated and distributed to the OMPP by the 20th business day of the following month.

Report Definition: Monthly Case Mix Audit Validation Percentage Report

Report Number

LTC-0005-M

Description of Information on the Report

This is a manually generated report listing each facility by provider name, city, and provider number in ascending alphabetical order. The report lists the total number of records reviewed, the percentage of valid records, the auditors who completed the on-site review, indication of whether a sample of records was audited or whether all records on the Myers & Stauffer roster were completed, and indication of whether or not a follow-up audit is needed, no sooner than six months.

The information is obtained from each on-site LTC review *Medicaid Audit Information (MAI)* form and is reviewed by the LTC staff member during the audit packet review done weekly. The information is entered onto the monthly Microsoft Excel report and then printed online.

Purpose of Report

To document on-site statistics from each facility reviewed during the month reported. The report is generated and distributed to the OMPP and to Myers & Stauffer by the 20th business day of the following month.

Report Definition: Monthly Follow-up Audit Report

Report Number

LTC-0006-M

Description of Information on the Report

This is a manually generated report listing those nursing facilities that have exceeded the current error threshold; by provider name, city, and provider number in chronological order. The report lists the last audit date, the original auditors, percentage of valid records, and follow-up audit month.

The information is obtained from each on-site LTC review *Medicaid Audit Information (MAI)* form and is reviewed by a LTC staff member during the audit packet review done weekly. The information is entered onto the Microsoft Excel report and then printed online.

Purpose of Report

To document those nursing facilities that exceed the current error threshold during the month reported. The report is generated and posted internally to the LTC L: drive.

Section 6: Forms

ATTACHMENT TALLY SHEET **FACILITY**_____ **PROVIDER #**_____

ADL's
G1a,A
G1a,B
G1b,A
G1b,B
G1i,A
G1i,B
G1hA

Special Care
I1w
I1z
I2g
K5b
M2a
M4b
P1a,c
P1a,h
B1
J1h
'I2e
'Jic
'J1o
'K3a

P1a,a
P1a,b
P1a,g
P1a,k
P1b,dA
P8
M4c or M4f
M5i or M6f
M4g
M5f
Depression Eval.
E2
'E1a
E1n
E1o
E1p
E4e,A
'E1j
'N1d
'N1a
N1b
'N1c
'B1
E1g
'K3a
I1ee
I1ff

Impaired Cognition
B2a
B3a
B3b
B3c
B3d
B4

Behavior Problems
E4a,A
E4b,A
E4c,A
E4d,A
J1e
J1i

Special Rehabilitation
P1b,a
P1b,b
P1b,c

Clinically Complex
I1r
I1s
I1v
I2e
I2j
J1c
J1j
J1k
J5c
M2b

Nsg. Rehab./Restor. Care
P3a
P3b
P3c
P3e
P3g
P3h
P3i
P3d or P3f
H3a

Extensive Services
K5a
P1a,i
P1a,j
P1a,l

PRELIMINARY DATA

Figure 6.1 – Example of Attachment Tally Sheet

CMHC/BDDS/ISDH MEMORANDUM

To: LTC Supervisor
From: _____
Date of Audit: _____
Facility Name _____
Address: _____
_____
Provider: _____

List the following information on residents being sent to CMHC/BDDS/ISDH

Resident Name: _____RID#_____
Reason: _____Level II Date_____
Resident Name: _____RID# _____
Reason: _____Level II Date _____
Resident Name: _____RID# _____
Reason: _____Level II Date _____
Resident Name: _____RID# _____
Reason: _____Level II Date _____
Resident Name: _____RID# _____
Reason: _____Level II Date _____

A. Level II – Is MI: MH services needed: Not Provided (ISDH & CMHC) SDOHMI01.DOC/SDOHMI02.DOC
B. Level II – Is Not MI: Past and/or current documentation present to support MI Dx:
Request final determination (CMHC) CMHCFIN.DOC
C. Level II – Is MR/DD Or MR/MI: Unsure if medical needs take precedence over active Tx:
Or
PAS Certification states is not MR/DD: Documentation present to Support MR/DD Dx
Request BDDS Clarification BDDSFIN.DOC
D. Level II – MR/DD Or MR/MI: MR/DD services needed: No Services provided (ISDH & BDDS)
ISDHMR01.DOC/ISDHMR02.DOC

Figure 6.2 – Example of CMHC/BDDS/ISDH Memorandum Form

END OF THERAPY

FACILITY NAME_____ **PROVIDER #**_____

	RESIDENT NAME	CONTINUING THERAPY YES/NO	END DATE OF LAST THERAPY RECEIVED	BC 2 RECORD YES/NO
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				
19				
20				

SUBMITTED BY :_____

DATE:_____

Figure 6.3 – Example of End of Therapy Worksheet

EXIT CONFERENCE PRELIMINARY FINDINGS

FACILITY_____

PROVIDER # _____

AUDIT DATE _____/_____/_____ **TO** _____/_____/_____

COPIES PROVIDED:

_____PROVIDER SUMMARY

_____EXIT CONFERENCE PRELIMINARY FINDINGS

_____SUPPORTIVE DOCUM. GUIDELINES (version 10/00)

_____OTHER:_____

SPECIAL AREAS FOR DISCUSSION:

_____

_____

_____

EXPANDED AUDIT _____**YES** _____**NO**

PRELIMINARY VALID_____**%**

SIGN IN FOR EXIT CONFERENCE
(PRINTED NAME, TITLE)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

PRELIMINARY STATISTICS REFLECT RECORDS TRANSMITTED THROUGH _____ **(DATE OF M&S ROSTER)**

RUG Category	Records Reviewed	Valid Records	Records in Error	Inaccurate Records
REHABILITATION				
EXTENSIVE SERVICES				
SPECIAL CARE				
CLINICALLY COMPLEX				
IMPAIRED COGNITION				
BEHAVIOR				
REDUCED PHYSICAL				
TOTAL				

I certify that the EDS auditors have been provided all the necessary medical documentation and/or other applicable records, in order to fully disclose the extent of services provided to facility residents.

Facility Staff Signature: _____ **Date:**_____

Printed Name and Title:_____

***Preliminary Information**

Figure 6.4 – Example of Exit Conference Preliminary Findings Sheet

Interagency Communication Form

Referral from:
Survey agency_____
Medicaid Audit_____
FI_____
Dept. of Health_____

Referral to:
Survey agency_____
Medicaid Audit_____
FI_____ _____
Dept. of Health_____

Date of Referral_____

Provider Name:	**Review Date:**
Provider Address:	
Provider Number:	**Referral Name:**
State of Provider:	**Referral Number:**

Specific MDS Issues:

MDS Item	MDS Item Description	*Type Of Referral	Description of Findings

Coverage Issues:

Patient Name	Date Observed of Billing Period	Patient Social Security Number	Description of Findings

Comments:

***Key:**
T – Trend **OS – Over statement**
F – Fraud **US – Under statement**

Figure 6.5 – Example of Interagency Referral Form

Provider Name
Provider Number

Indiana Office of Medicaid Policy and Planning
MDS Audit Worksheet

Audit Dates: _____

Resident Name _____
SSN # _____
RID # _____
Birthdate_____ **Admission Date** _____
Diagnosis _____

Last Level II Date _____ **MH Assess**
MI/DD: Y N Serv. Prov Y N
DX:

Recommendation:

450B Date: _____ **IN PROC ABSENT N/A**
Meets NF Criteria Y N 1-3-1 405 IAC 1-3-2
Auditor _____|_____|_____ **Rev. Date** _____
Reviewing MD _____ **Rev. Date** _____
Agree Disagree

Record Type _____
Trans RUG Code _____
Start Observation Date _____ **AB1 date**
A3a Date _____
Nsg Restorative _____
Trans ADL Score _____
Audited ADL Score _____

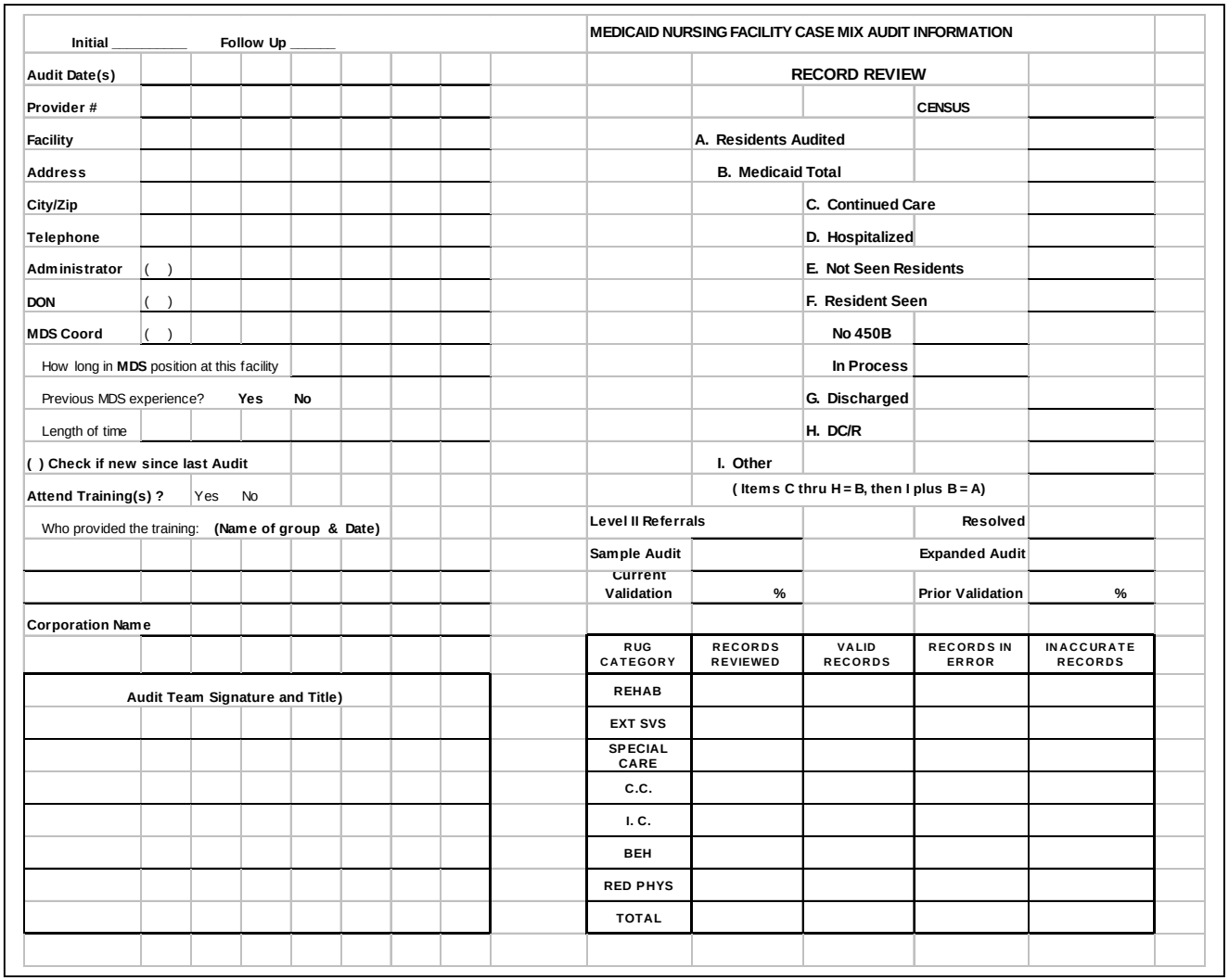
ADL Score Unsupported? **YES NO**
Element Unsupported? **YES NO**
EOT Date _____
A3a date exceeds 10 days **YES NO**
SCSA Date _____
SCSA exceeds 14 days? **YES NO**
RUG Change? **YES NO**

# of Records Reviewed _____
# of Erred Records _____

D/C D/CR R

MDS ADL Fields			Documentation			
Item No.	Description	Transmitted Value	Supports Reported Value?		Audited Value	Comments
	Bed Mobility					
1 G1a.A	Self Perf		Yes ☐	No ☐		
	Bed Mobility					
2 G1a.B	Support		Yes ☐	No ☐		
	Transfer					
3 G1b.A	Self Perf		Yes ☐	No ☐		
	Transfer					
4 G1b.B	Support		Yes ☐	No ☐		
	Toilet Use					
5 G1i.A	Self Perf		Yes ☐	No ☐		
	Toilet Use					
6 G1i.B	Support		Yes ☐	No ☐		
	Eating					
7 G1h.A	Self Perf		Yes ☐	No ☐		
8			Yes ☐	No ☐		
9			Yes ☐	No ☐		
10			Yes ☐	No ☐		
11			Yes ☐	No ☐		
12			Yes ☐	No ☐		
13			Yes ☐	No ☐		
14			Yes ☐	No ☐		
15			Yes ☐	No ☐		
16			Yes ☐	No ☐		
17			Yes ☐	No ☐		
18			Yes ☐	No ☐		

Figure 6.6 – Example of MDS Audit Worksheet



Initial _____ Follow Up _____

MEDICAID NURSING FACILITY CASE MIX AUDIT INFORMATION

Audit Date(s)

Provider #

Facility

Address

City/Zip

Telephone

Administrator ( )

DON ( )

MDS Coord ( )

How long in **MDS** position at this facility

Previous MDS experience? **Yes** **No**

Length of time

( ) Check if new since last Audit

Attend Training(s) ? Yes No

Who provided the training: **(Name of group & Date)**

Corporation Name

Audit Team Signature and Title)

RECORD REVIEW

CENSUS

A. Residents Audited

B. Medicaid Total

C. Continued Care

D. Hospitalized

E. Not Seen Residents

F. Resident Seen

No 450B

In Process

G. Discharged

H. DC/R

I. Other

(Items C thru H = B, then I plus B = A)

Level II Referrals **Resolved**

Sample Audit **Expanded Audit**

Current Validation % **Prior Validation** %

RUG CATEGORY	RECORDS REVIEWED	VALID RECORDS	RECORDS IN ERROR	INACCURATE RECORDS
REHAB				
EXT SVS				
SPECIAL CARE				
C.C.				
I. C.				
BEH				
RED PHYS				
TOTAL				

Figure 6.7 – Example of Medicaid Audit Information (MAI) form

MEMORANDUM

TO: _____

FROM: _____

DATE: _____

RE: _____

Figure 6.8 – Example of Memorandum

MEMORANDUM

TO: LTC Supervisor

FROM: _____

DATE: _____

SUBJECT: Not seen resident(s)_____

_____

Resident Name: _____

RID Number: _____

Facility Name: _____

Provider Number: _____

Date of Audit: _____

Arrangements for seeing resident: _____

_____

_____

_____

Copy of worksheet in packet Yes No

Figure 6.9 – Example of Not Seen Resident(s) Memorandum

NURSING FACILITY AUDIT INFORMATION

Effective August 1, 1992, the EDS audit teams will be requesting that nursing facilities provide documentation of the total number of residents in the facility, as well as the number of residents having a PASRR Level II due to a mental illness (MI) diagnosis. This information must be certified by the facility staff at the time of the audit. EDS will forward this information to OMPP in order to assist Indiana Medicaid in complying with federal reporting requirements.

FACILITY MI STATISTICS

Total number of residents in facility (census) _____ Facility staff initials _____

Number of residents having an active MI diagnosis verified by Level II ****** (including MI/MR diagnosed residents): _____ Facility staff initials _____

Number of residents currently receiving specialized services per Level II: _____ Facility staff initials _____

****NOTE: Apply federal PASRR definitions/criteria to determine active MI diagnosis.**

I CERTIFY THAT THIS IS A COMPLETE AND ACCURATE ACCOUNT OF ALL RESIDENTS WITH AN APPLICABLE MI DIAGNOSIS.

SIGNIFICANT CHANGE RR

The following residents have been identified as requiring a Level II in accordance with procedures for Significant Change RR in Chapter 210.3 (Indiana IPAS/PASRR Program Manual)

_____

_____ EDS Staff Initials_____

LEVEL I ASSURANCE

I certify that PASRR Level I's are present and accurately reflect **ALL** residents.

_____ _____
Signature Title

_____ _____
Facility Name Provider Number

_____
Date

Names of missed Level II residents will be provided to the NF in Facility Audit Letter.

Figure 6.10 – Example of Nursing Facility Audit Information Worksheet

Nursing Facility Entrance Conference for EDS Review Teams

Facility Name:_____

Provider #: _____

Entrance Date: ___/___/___

EDS Members Present:_____

Facility Members Present:_____

The purpose of the EDS Medicaid Review is to examine the MDS in depth and validate supportive documentation. The team will observe each resident included in the sample as well as review the chart and other pertinent documentation. At the discretion of the team, observation of the provision of therapy and nursing restorative services may be included as part of the review process.

Once the review is complete, an exit conference will be held with the facility staff to discuss the review team findings and recommendations.

Supportive documentation to validate the MDS will be found in the following locations:

_____

_____

_____

_____

_____

_____

Staff Liaison Signature

Figure 6.11 – Example of Nursing Facility Entrance Conference Sheet

DATE

Administrator
Facility Name
Street Address
City, State Zip
Provider Number

Dear Administrator's Name:
On October 1, 1998, the Indiana Office of Medicaid Policy and Planning (OMPP) implemented a new case mix reimbursement system for nursing facility services. In this system, each resident is classified based upon responses indicated on the MDS assessment, which must be validated with supporting documentation in the medical record.

The OMPP MDS audit contractor, EDS, has recently conducted an audit of your MDS records. Their audit included a review of either a sample or 100% of your residents' medical records. An MDS record is considered inaccurate when the EDS audit team is not able to locate the appropriate documentation in the medical record to support the MDS responses that classified the resident, and the audited MDS values result in a different RUG-III classification for that MDS record. The results of the audit are reflected on MDS audit worksheets. Please find attached copies of MDS audit worksheets for audited records that were erred. For a complete listing of all MDS elements and supportive documentation guidelines for each RUG category, please refer to EDS Provider Bulletin No. BT200040 dated October 1, 2000, which contains the latest version of the Supportive Documentation Guidelines published by the OMPP.

The results of the MDS audit are also summarized below.

- **% of the audited MDS records were validated**

The percent of audited MDS records from your facility that were inaccurate, segregated by RUG-III category, are summarized below.

A. Rehabilitation: _____ records inaccurate

B. Extensive Services: _____ records inaccurate

C. Special Care: _____ records inaccurate

D. Clinically Complex: _____ records inaccurate

E. Impaired Cognition: _____ records inaccurate

F. Behavior Problem: _____ records inaccurate

G. Reduced Physical Function: _____ records inaccurate

Figure 6.12 – Example of Nursing Facility Letter #1 (part 1 of 2)

In the event that the overall percentage of your audited MDS records that were validated is less than the 65% threshold, please provide to EDS in writing a Validation Improvement Plan (VIP). The VIP should outline the additional procedures you propose that will ensure future compliance with the documentation guidelines, along with an anticipated implementation timeline. This information should be submitted for each category of MDS audit error that is noted on the attached MDS audit worksheets. A suggested VIP format has been included for your consideration. The EDS Long Term Care Review Team may conduct subsequent visits to your facility to determine if the VIP has been fully implemented. These visits may be made without prior notification to the facility.

These MDS audit findings have been forwarded to the Office of Medicaid Policy and Planning (OMPP), and OMPP's long-term care rate-setting contractor, Myers and Stauffer LC, for recalculation of the RUG III classifications. Additionally, beginning October 1, 1999, corrective remedies will apply for those nursing facilities that do not have 50% or more of their audited MDS records validated as fully supported. Should the MDS audit findings affect your current case mix index (CMI), you will receive an updated time weighted CMI report and a Notice of New Medicaid Rates from Myers and Stauffer LC.

Should you disagree with the enclosed MDS audit findings, you may request informal reconsideration by making a notation of this on your VIP. The informal reconsideration request must include specific audit issues that the facility believes were misinterpreted or misapplied during the audit. It should be noted that MDS supporting documentation that is provided after the audit exit conference shall not be considered in the reconsideration process. Your written response must be received within fifteen (15) business days from the date of this letter. Please forward to the following address:

EDS Long Term Care Review
950 N. Meridian Street, Suite 1150
Indianapolis, IN 46204-4288

We sincerely appreciate your cooperation with the review process and thank you for the care you render to Indiana's Medicaid residents. Should you have any questions relative to this matter, please do not hesitate to direct them to me at (317) 488-5099.

Sincerely,
Lori Bergschneider, Supervisor
Long Term Care

Cc: Mary Gordon
Office of Medicaid Policy and Planning

Health Facilities Division
Indiana State Department of Health

Figure 6.12 – Example of Nursing Facility Letter #1 (part 2 of 2)

Nursing Facility Level Of Care Additional Documentation			
Resident's Name	DOB: DOA:		SS #: RID #:
Nursing Facility Name/Address/City:			
Completed By:	Date:	Credentials:	Provider #:
Items checked are those where information was not available in the resident's file/chart. Please pay attention to any information that might be available in these areas. Any additional or *new* information in these areas that may be helpful should be provided. Supporting documentation may be attached. When completed, send to: EDS, 950 N. Meridian, Suite 1150, Indianapolis, IN. 46204-4288.			
❒ Medical Issues / Medications:			
❒ Personal Safety Issues / Mental Status / Orientation:			
❒ Barriers to Functioning in a Less Restrictive Setting:			
❒ Activities of Daily Living: Communication: Transfer ISA Eating ISA Vision: Ambulation ISA Bathing ISA Hearing: Assistive Devices: Dressing ISA Bowel & Bladder: Hygiene ISA			
❒ Previous Residential Placements:			
❒ Frailty and Adjustment Issues:			
❒ Alternative Placements Explored:			
❒ Resident's Informal Supports:			
❒ Resident and/or Family Involvement in Discharge Planning:			

Figure 6.13 – Example of Nursing Facility Level of Care Additional Documentation Form

NURSING FACILITY POSTREVIEW CHECK LIST

FACILITY_____ **PROVIDER #**_____

AUDIT DATE (s)_____ **CENSUS**_____

NAME AND RUG CATEGORY OF RESIDENTS WHO ARE REFERRED FOR DISCHARGE, DC/R OR LEVEL II

NAME	**RUG CATEGORY**

PACKET ORDER:

1. **MAI**
2. **Time Study forms**
3. **TBI Resident Sheet**
4. **Memo to LTC Supervisor (if applicable)**
5. **Nursing Facility Post Review Check List**
6. **Attachment Tally Sheet**
7. **Provider Summary**
8. **Resident List**
9. **End of Therapy List**
10. **NOT VALID worksheets**
11. **M & S Roster**
12. **VALID worksheets**
13. **Ad Hoc**
14. **MI Stat Sheet**
15. **MI/MR/DD List**
16. **Exit Conference Sheet**
17. **Entrance Conference form**
18. **Phone Contact Sheet**

REVIEW TEAM
INITIALS_____

Figure 6.14 – Example of Nursing Facility Postreview Checklist

Phone Contact Sheet

Provider Name_____Provider #_____

Facility Phone Number_____FAX #_____

Date & Time Phoned_____Date of Audit_____

1.) Introduction_____(Your name, EDS /Medicaid Indianapolis)

2.) Request to speak to Administrator or Director of Nursing.

Person information was given to & title_____

3.) Calling to notify the facility of upcoming audit date and time.

4.) **CENSUS**_____

5.) The Audit Team will consist of _____RN(s) and/or _____SW(s).

6.) Review with the facility the needs of the team as outlined in the policies and procedures.

7.) Who will be the facility contact person? _____

8.) If any questions arise, please feel free to contact our office at (317)488-5099

Directions to audit site:_____

_____

_____

_____

_____

Figure 6.15 – Example of Phone Contact Sheet

REFERRAL FORM

TO: Post-payment Review

FROM:

DATE:

SUBJECT: Provider / Recipient Referral

_____

Provider / Recipient Name: _____

_____

Provider Type / Specialty: _____

OR

Recipient Age and Class Group: _____

Reason for Referral: _____

_____

_____

_____

_____

FOR MANAGEMENT USE

Copies of pertinent documentation are attached to this memo for review.

Eligibility Status: _____

Audited Within Past Nine Months (Y/N) _____

Disposition of Previous Audits: _____

Documentation Reviewed: _____

History/PDR/Summary Profile/Other (specify source)

_____

_____

Legal and/or Administrative Disposition: _____

_____

Figure 6.16 – Example of Postpayment Review Referral Form

Indiana Office of Medicaid Policy and Planning
MDS Audit Worksheet
Provider Summary / Preliminary Findings

Page ____ of _____

Provider: _____ **Provider #** _____

Audit Dates: _____ to _____

Resident Name	SSN	A3a Date	Record Type	No. of Records Reviewed*	No. of Inaccurate Records*

**** Include any omitted untimely records.***

# of Records Reviewed = _____

# of Inaccurate Records = _____

Provider Error Rate = _____ %

(# of Inaccurate Records / # of Records Reviewed)

Figure 6.17 – Example of Provider Summary/Preliminary Findings Worksheet

TRAUMATIC BRAIN INJURY RESIDENTS

FACILITY NAME **PROVIDER #**

AUDIT DATE

FOR OFFICE USE ONLY:
RATE: **DATE:**

NAME:			**PRIMARY DX:**
RID or SSN:			**SECONDARY DX:**
DOB:	**MR/DD per Level II:**	**DATE OF TBI:**	**REASON FOR TBI:**
DOA:	**YES NO**	**RUG CLASS:**	**RECEIVING ACTIVE TREATMENT / TYPE:**

NAME:			**PRIMARY DX:**
RID or SSN:			**SECONDARY DX:**
DOB:	**MR/DD per Level II:**	**DATE OF TBI:**	**REASON FOR TBI:**
DOA:	**YES NO**	**RUG CLASS:**	**RECEIVING ACTIVE TREATMENT / TYPE:**

NAME:			**PRIMARY DX:**
RID or SSN:			**SECONDARY DX:**
DOB:	**MR/DD per Level II:**	**DATE OF TBI:**	**REASON FOR TBI:**
DOA:	**YES NO**	**RUG CLASS:**	**RECEIVING ACTIVE TREATMENT / TYPE:**

NAME:			**PRIMARY DX:**
RID or SSN:			**SECONDARY DX:**
DOB:	**MR/DD per Level II:**	**DATE OF TBI:**	**REASON FOR TBI:**
DOA:	**YES NO**	**RUG CLASS:**	**RECEIVING ACTIVE TREATMENT / TYPE:**

NAME:			**PRIMARY DX:**
RID or SSN:			**SECONDARY DX:**
DOB:	**MR/DD per Level II:**	**DATE OF TBI:**	**REASON FOR TBI:**
DOA:	**YES NO**	**RUG CLASS:**	**RECEIVING ACTIVE TREATMENT / TYPE:**

NOTE: Any treatment for a sign/symptom related to direct dx. of TBI (i.e., Nsg. Restor., Rehab., Psych Svs., Behavior plan, etc.)

Figure 6.18 – Example of Traumatic Brain Injury Form

FACILITY NAME _____

SAMPLE SIZE_____ **AUDIT DATES**_____

MINUTES	TASK	
	CALL FACILITY	
	ENTRANCE CONFERENCE (Include time completing the TBI form)	
	450B/PASRR WAIT TIME (if any)	
	REVIEW LISTS (includes wait time)	
	COMPLETE PROVIDER SUMMARY (This includes initial completion and final completion to give facility)	
	PUT ON HEADERS (if applicable)	
	REVIEW LEVEL II RESIDENTS NOT SAMPLED	
TOTAL MINUTES PER RUG	**CHART AUDIT:**	**TOTAL # COMPLETED (SEE MAI)**
	REHAB	
	EXTENSIVE SERV.	
	SPECIAL CARE	
	CLINICALLY COMPLEX	
	IMP COGN	
	BEHAVIOR	
	REDUCED PHYSICAL	
	OBSERVE RESIDENTS (Include total time Auditors observe)	
	COMPLETE AD HOC (Includes time to do resolves and to complete)	
	COMPLETE PAPERWORK (ONLY count time completing the MI stat sheet and other forms not noted in the above)	
	EXIT CONFERENCE (This includes completing the Exit Conference form)	
	COMPLETE ATTACHMENT	
	CHECKING & PUTTING PACKET IN ORDER	
	EDUCATION / IN-SERVICE TIME	
	OFF-SITE TIME	

Figure 6.19 – Example of Time Study Form

Indiana Office of Medicaid Policy and Planning
VALIDATION IMPROVEMENT PLAN

(facility name)
(provider #)

THE VALIDATION IMPROVEMENT PLAN IS DUE TO EDS NO LATER THAN:

	Audit Exit Date:		**Valid Record %**
AREAS REQUIRING IMPROVEMENT	**FACILITY REMEDY**	**COMPLETION DATE**	**PERSON RESPONSIBLE**

Administrator or Designee Signature_____

Date_____

Figure 6.20 – Example of Validation Improvement Plan

Section 7: Frequently Used Drugs List

Overview

The following is a list of commonly used and prescribed medications found in facilities. They are classified according to their therapeutic uses by brand name, then generic.

Antipsychotics

- Compazine (prochlorperazine)
- Haldol (haloperidol)
- Lithium
- Mellaril (thioridazine)
- Moban (molindone)
- Navane (thiothixene)
- Prolixin (fluphenazine)
- Risperdal
- Serentil (mesoridazine)
- Stelazine (trifluoperazine)
- Thorazine (chlorpromazine)
- Trilafon (perphenazine)

Antidepressants

- Asendin (amoxapine)
- Desyrel (Trazodone)
- Elavil (amitriptyline)
- Lithonate (Lithium)
- Nardil (phenelzine)
- Norpramin (desipramine)
- Pamelor (Nortriptyline)
- Paxil (paroxetine)
- Prozac (fluoxetine)

- Sinequan (doxepin)
- Tofranil (imipramine)
- Wellbutrin (bupropion)
- Zoloft (sertraline)

Hypnotics

- Ambien
- Dalmane (flurazepam)
- Halcion (triazolam)
- Placidyl (ethchlorvynol)
- Restoril (Temazepam)
- Seconal (secobarbital)

Anti-Anxietys

- Atarax (hydroxyzine)
- Ativan (lorazepam)
- Buspar (buspirone)
- Equanil (meprobamate)
- Librium (chlordiazepoxide)
- Noctec (chloral hydrate)
- Serax (oxazepam)
- Tranxene (clorazepate)
- Valium (diazepam)
- Vistaril (hydroxyzine)
- Xanax (alprazolam)

Analgesics

- Codeine
- Darvocet/Darvon (propoxyphene hcl)
- Demerol (meperidine hcl)
- Duragesic (fentanyl transdermal)

- Percocet (oxycodone hcl)
- Roxanol (morphine Sulfate)
- Ultram (tramadol hcl)
- Vicodin (hydrocodone bitartrate)

Antihistamines

- Allegra (fexofenadine hcl)
- Benadryl (diphenhydramine hcl)
- Claritin (loratadine)
- Chlor-Trimeton (chlorpheniramine maleate)
- Hismanal (astemizole)
- Seldane (terfenadine)
- Tavist (clemastine fumarate)
- Zyrtec (cetirizine hcl)

Anticonvulsants

- Cerebyx (fosphentoin sodium)
- Depakene (valproate sodium)
- Depakote (divalproex sodium)
- Dilantin (phenytoin)
- Gabitril
- Klonopin (clonazepam)
- Lamictal (lamotrigine)
- Milontin (phensuximide)
- Mysoline (primidone)
- Neurontin (gabapentin)
- Phenobarbital
- Tegretol (carbamazepine)
- Topamax (topiramate)
- Zarontin (ethosuximide)

Chemotherapy/Antineoplastics

- Altretamine/Hexalen
- Amifostine/Ethyol
- Anastrozole
- Asparaginase/Elspar
- Cladribine
- Cyclophosphamide/Cytoxan
- Docetaxel/Taxotere
- Gemcitabine hcl/Gemzar
- Interferon:
  - Alfa-2a
  - Alfa-2b
  - Alfa-n3
  - Beta-1a
  - Beta-1b
  - Gamma-1b
- Irinotecan hcl/Camptosar
- Megestrol acetate/Megace
- Methotrexate
- Mitotane/Lysodren
- Mitoxatrone hcl/Novantrone
- Paclitaxel/Taxol
- Pentostatin
- Porfimer sodium
- Procarbazine hcl
- Rituximab/Rituxan
- Tamoxifen/Nolvadex
- Vinblastine sulfate
- Vincristine sulfate/Oncovin
- Vinorelbine tartrate/navelbine

Section 8: Research/Project Tracking System

Overview

The Research/Project Tracking System (RPTS) is a Windows-based tool accessible through Indiana*AIM*. The RTPS application assists in tracking Medicaid program inquiries that require extended research. These inquiries may originate as Provider/Recipient phone calls that cannot be resolved during the initial conversation. Other inquiries may come to the OMPP, EDS, or HCE as written correspondence. This tool also tracks requests for information and/or assistance between Medicaid contractors and requests for information made by the OMPP staff.

Data collected from the **RPTS** is used to evaluate performance issues, provide insight into inquiry trends, and help measure the overall "health" of EDS delivery of customer service.

The LTC Unit handles 450B and Level-of-care issues through the RTPS. These are inquiries that may come from providers or recipients.

RPTS Windows

The RTPS tool uses four primary windows, accessed through the Indiana*AIM* Main Menu, to capture and maintain information specific to each request or query.

RPTS Main Menu

The RPTS Main Menu window functions like a switchboard, providing access to the New Request, Search and Maintenance windows. **Maintain** on this window requires entering a specific record ID (Control#) for editing.

RPTS New Request

The RPTS New Request window is used to enter detailed information for a new RPTS record. Information about the requester and the person who received the request is required. Information about the person assigned to resolve the query is optional on new requests. A brief description of the request is also required.

RPTS Search

The RPTS Search window provides the ability to locate a group of records or a specific record on the database and then edit or print the record(s). Many search options are available and combinations of search criteria may be used to widen or narrow a search.

RPTS Maintenance

The RPTS Maintenance window is used to edit the detailed information in a record and create a daily status entry. This window is invoked by using **Maintain** and **go** on the RPTS Main Menu by using **Select** on the RPTS Search window (also double-click on a record in the RPTS Search window Search Results Pane). The person identified as the "Assignee" has the ability (obligation) to create/update a daily status entry.

Glossary

590 Program	A state of Indiana medical assistance program for institutionalized persons under the jurisdiction of the Department of Corrections, Division of Mental Health, and Department of Health.
ADL	Activities of Daily Living. Basic self-care activities engaged in by adults to maintain health and social acceptability, such as bathing, dressing, mobility, toileting, eating, and transferring.
Ad hoc Report	A facility/recipient quarterly inspection of care report.
administrative component	This is one of four case mix components used to calculate rates. It includes allowable administrator and co-administrator services; owner's compensation (including director's fees) for patient-related services; services and supplies of a home office that are allowable and patient-related and are appropriately allocated to the nursing facility; office and clerical staff; legal and accounting fees; advertising; travel; telephone; license dues and subscriptions; office supplies; working capital interest; state gross receipts taxes; utilization review costs; liability insurance; management; and other consultant fees.
ARCH	Aid to Residents in County Homes. A State-funded program that provides medical services to certain residents of county nursing homes.
auto assignment	Indiana*AIM* process that automatically assigns a managed care recipient to a managed care provider if the recipient does not select a provider within a specified time frame.
AVR	Automated voice-response system used by providers to verify recipient eligibility by phone.
AWP	Average wholesale price used for drug pricing.
BBS	Bulletin Board System. In Indiana, a BBS is used for IHCP facilities to send assessment data and receive validation reports. A bulletin board system consists of a computer running specialized software allowing information to be exchanged electronically (via modem). Multiple users can be logged in at one time, each with their own private session.
BC2	An untimely record not transmitted within 113 days or an End of Therapy record not transmitted in a timely manner per regulations.
BDDS	Bureau of Developmental Disabilities Services.

bedhold	An IHCP resident can be admitted to the hospital and have the nursing facility bed held at half the IHCP rate with IHCP reimbursement to the facility being continued. A nursing facility bed may be held for a maximum of 15 days per hospital admission.
BENDEX	Beneficiary Data Exchange. A file containing data from HCFA regarding persons receiving Medicaid benefits from the Social Security Administration.
bill	Refers to a bill for medical services, the submitted claim document, or the electronic media claims (EMC) record. A bill may request payment for one or more performed services.
buy-in	A procedure whereby the State pays a monthly premium to the Social Security Administration on behalf of eligible medical assistance recipients, enrolling them in Medicare Part A or Part B or both programs.
capital components	This is one of the four case mix components used to calculate rates. It includes all remuneration for capital costs, the allowable fair rental value allowance, property taxes, property insurance, and repairs and maintenance.
case	This refers to the overall data collected and used regarding an individual person under study. It describes the combination of variables (observations) used for classifying and observation according to distinctive characteristics on the basis of dependent variable, such as time or costs.
case mix	A system of paying nursing facilities according to the mix of residents in each facility as measured by resident characteristics and service needs. Its function is to provide payment for resources needed to serve different types of residents.
case mix payment	The payment to a nursing facility, per resident or per facility, based on the facility's IHCP case mix. Also used as a term to identify a type of nursing facility payment system based on resident resource levels.
case mix weight (index)	Each RUG-III group is assigned a weight, or numeric score, that reflects the relative resources predicted to provide care to a resident. The higher the case mix weight, the greater the resource requirements are for the IHCP resident.

CCF	Claim correction form. A CCF is generated by Indiana*AIM* and sent to the provider who submitted the claim. The CCF requests the provider to correct selected information and return the CCF with the additional or corrected information.
CCN	Cash control number. A financial control number assigned to identify individual transactions.
certified beds	Beds in a facility authorized to receive government reimbursement.
CFR	Code of Federal Regulations. Federal regulations that implement and define federal Medicaid law and regulations.
CHIP	Children's Health Insurance Program
claim	A provider's request for reimbursement of IHCP-covered services. Claims are submitted to the State's claims processing contractor using standardized claim forms: HCFA-1500, UB-92, ADA Dental Form, and State-approved pharmacy claim forms.
CLIA	Clinical Laboratory Improvement Amendments. A federally mandated set of certification criteria and a data collection monitoring system designed to ensure the proper certification of clinical laboratories.
clinical hierarchy	Categories formed using resident conditions and services to classify residents into major types by staff time received or costs. For the RUG-III system, this includes services named resident groups: Special Rehabilitation, Extensive Services, Special Care, Clinically Complex, Impaired Cognition, Behavioral Problems, and Reduced Physical Functions.
CMHC	Community Mental Health Center
comprehensive assessment	Assessment including completion of full MDS, review of triggered RAPS, and development or review of a comprehensive care plan within seven days of completing the MDS and RAPS. This assessment must be completed by day 14 of the residents stay.
continued care	Residents mark nursing on the Ad hoc Report indicating that the IHCP level-of-care is continued.

contract amendment	Any written alteration in the specifications, delivery point, rate of delivery, contract period, price, quantity, or other contract provisions of any existing contract, whether accomplished by unilateral action in accordance with a contract provision, or by mutual action of the parties to the contract. It includes bilateral actions, such as change orders, administrative changes, notices of termination, and notices of the exercise of a contract option.
contractor, contractors, or the contractor	Refers to all successful bidders for the services defined in any contract.
core contractor	The successful bidder on *Service Package #1: Claims Processing and Related Services*.
core services	Refers to *Service Package #1: Claims Processing and Related Services*.
county office	County offices of the Division of Family and Children. Offices responsible for determining eligibility for IHCP using the Indiana Client Eligibility System (ICES).
covered service	Mandatory medical services required by HCFA and optional medical services approved by the State. Enrolled providers are reimbursed for these services provided to eligible IHCP recipients.
CPAS	Claims Processing Assessment System. An automated claims analysis tool used by the State for contractor quality control reviews.
CRF/DD	Community Residential Facility for the Developmentally Disabled.
CSHCS	Children's Special Health Care Services. A State-funded program providing assistance to children with chronic health problems. CSHCS recipients do not have to be IHCP-eligible. If they are also eligible for Medicaid, children can be enrolled in both programs.
CSR	Customer service request.
customer	Individuals or entities that receive services or interact with the contractor supporting the IHCP, including State staff, recipients, and Medicaid providers (managed care PMPs, managed care organizations, and waiver providers).
D/C-R	Discharge Referral. No medical care needs found for residents with MI and MR/DD diagnosis.
DD	Developmentally Disabled
Decision Tree	A flow chart used for determining ADL self-performance score.

designee	A duly authorized representative of a person holding a superior position.
DHHS	U.S. Department of Health and Human Services. DHHS is responsible for the administration of Medicaid at the federal level through the Health Care Financing Administration.
direct care component	This is one of the four Case Mix components used to calculate rates. It includes all allowable nursing and nursing aide services, nurse consulting services, pharmacy consultants, medical director services, nurse aide training, medical supplies, oxygen, therapy services, and medical records costs.
DME	Durable medical equipment. Examples: wheelchairs, hospital beds, and other nondisposable, medically necessary equipment.
download	Computer files transferred (via modem) from another computer to the user's computer. This is the opposite of uploading files.
Download Directory	A directory on BBS where validation report(s) are stored. Any file that is stored in the download directory can be downloaded. (IHCP-only)
DPOC	Data Processing Oversight Commission. An Indiana state agency that oversees agency compliance with all state data processing statutes, policies, and procedures.
DRG	Diagnosis-related grouping. Used as the basis for reimbursement of inpatient hospital services.
DSH	Disproportionate share hospital. A category defined by the State identifying hospitals that serve a disproportionately higher number of indigent patients.
DSS	Decision Support System. A data extraction tool used to evaluate Medicaid data, trends, and so forth, for the purpose of making programmatic decisions.
dually certified beds	Beds in a facility that are certified for Medicare (Title 18) and Medicaid (Title 19) reimbursement.
DUR	Drug Utilization Review. A federally mandated, Medicaid-specific prospective and retrospective drug utilization review system and all related services, equipment, and activities necessary to meet all applicable federal DUR requirements.
EAC	Estimated acquisition cost of drugs. Federal pricing requirements for drugs.

ECC	Electronic claims capture. Refers to the direct transmission of electronic claims over phones lines to Indiana*AIM*. ECC uses point-of-sale devices and PCs for eligibility verification, claims capture, application of Pro-DUR, prepayment editing, and response to and acceptance of claims submitted on-line. Also known as ECS and EMC.
ECS	Electronic claims submittal. Claims submitted in electronic format rather than paper. See ***ECC, EMC***.
edit validation	Rules that govern the collection and storage of data in any computerized system. In a computer database application, validations are rules to ensure that only valid data is stored.
EDP	Electronic data processing.
EFT	Electronic funds transfer. Paying providers for approved claims via electronic transfer of funds from the State directly to the provider's account.
EMC	Electronic media claims. Claims submitted in electronic format rather than paper. See ***ECC, ECS***.
EOB	Explanation of benefits. An explanation of claim denial or reduced payment included on the provider's remittance advice.
EOMB	Explanation of Medicare benefits. A form provided by Indiana*AIM* and sent to recipients. The EOMB details the payment or denial of claims submitted by providers for services provided to recipients.
EOP	Explanation of payment. Describes the reimbursement activity on the provider's remittance advice (RA).
EOT	End of therapy
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment program. Known as HealthWatch in Indiana, EPSDT is a program for Medicaid-eligible recipients under the age of 21 offering free preventive health care services, such as: screenings, well-child visits, and immunizations. If medical problems are discovered, the recipient is referred for further treatment.
EVS	Eligibility Verification System. A system used by providers to verify recipient eligibility using a point-of-sale device, on-line PC access, or an automated voice response system.
FAC-ID	Facility identifier. A unique number assigned to all facilities by the Indiana State Department of Health.

facility list	This is the list nursing facilities provide to the auditors that contains current residents in the facility and those residents on LOA and on hospital bedhold status. The term is used synonymously with the nursing facility resident list.
fatal (critical) record error	A record is rejected due to insufficient information to identify the resident and the type of record.
fatal file error	This occurs when an entire file is rejected due to flaws in the basic structure an integrity of the submission file.
FEIN	Federal employer identification number. A number assigned to businesses by the federal government.
FFP	Federal financial participation. The federal government reimburses the State for a portion of the IHCP administrative costs and expenditures for covered medical services.
FIPS	Federal information processing standards.
fiscal year - federal	October 1 - September 30.
fiscal year - Indiana	July 1 - June 30.
forms	• 450B: Certification by physician for LTC services • 1702: An appealed LOC decision. The hearing decision by a judge is attached to the form. • 1703: Form completed when there is agreement with LOC transfer/discharge recommendations • 1704: Notification of intermediate LOC, following a short-term skilled approval. Usually attached to the 450B, which has short-term determination dates. • 4B: Indiana PAS/PASRR Assessment Determination. This is the assessment form received for residents to see if they meet the State criteria for facility placement.
FSSA	Family and Social Services Administration. The Office of Medicaid Policy and Planning (OMPP) is a part of the FSSA. FSSA is an umbrella agency responsible for administering most Indiana public assistance programs. However, the OMPP is designated as the single State agency responsible for administering the IHCP.
full assessment	An MDS assessment containing Sections A-R completed on admission, annually, and for significant changes.
H & P	History and physical

HCBS	Home- and Community-Based Services waiver programs. A federal category of Medicaid services, established by Section 2176 of the Social Security Act. HCBS includes: adult day care, respite care, homemaker services, training in activities of daily living skills, and other services that are not normally covered by Medicaid. Services are provided to disabled and aged recipients to allow them to live in the community and avoid being placed in an institution.
HCE	Health Care Excel
HCFA	Health Care Financing Administration. The federal agency in the Department of Health and Human Services that oversees the Medicaid and Medicare programs.
HCFA-1500	HCFA-approved standardized claim form used to bill professional services.
HCI	Hospital Care for the Indigent. A program that pays for emergency hospital care for needy persons who are not covered under any other medical assistance program.
HCPCS	HCFA Common Procedure Coding System. A uniform health care procedural coding system approved for use by HCFA. HCPCS includes all subsequent editions and revisions.
HealthWatch	Indiana's preventive care program for IHCP recipients under 21 years of age. Also known as EPSDT.
HIC	Health insurance carrier number.
HIO	Health insuring organization.
HMO	Health maintenance organization.
Hoosier Healthwise	Indiana Medicaid managed-care program. Hoosier Healthwise has three components including Primary Care Case Management (PCCM), Risk-Based Managed Care (RBMC), and fee-for-service.
HRI	Health-related items.
IAC	Indiana Administrative Code
ICD-9-CM	International Classification of Diseases, 9th Revision, Clinical Modification. ICD-9-CM codes are standardized diagnosis codes used on claims submitted by providers.

ICES	Indiana Client Eligibility System. Caseworkers in the county offices of the Division of Family and Children use this system to help determine applicants' eligibility for medical assistance, food stamps, and Temporary Assistance for Needy Families (TANF).
ICF/MR	Intermediate care facility for the mentally retarded. An ICF/MR provides residential care treatment for Medicaid-eligible, mentally retarded individuals.
ICN	Internal control number. Number assigned to claims, attachments, or adjustments received in the fiscal agent contractor's mailroom.
IDOA	Indiana Department of Administration. Conducts State financial operations including: purchasing, financial management, claims management, quality assurance, payroll for State staff, institutional finance, and general services such as leasing and human resources.
IMD	Institutions for mental disease.
Indiana*AIM*	Indiana Advanced Information Management system. The State's current Medicaid Management Information System (MMIS).
IndianaAIM number	A unique number assigned to all Indiana Medicaid-certified nursing facilities. The number is referred to on the MDS 2.0 as the State facility provider number. (AA6a)
indirect care component	This is one of four case mix components used to calculate rates. It includes allowable dietary services and supplies, raw food, patient laundry services and supplies, patient housekeeping services and supplies, plant operations services and supplies, utilities, social services and supplies, and activity services and supplies.
Internet	World Wide Web
Intranet	A limited access server where only specified users have access to its use.
IOC	Inspection of care. A core contract function reviewing the care of residents in psychiatric hospitals and ICFs/MR. The review process serves as a mechanism to ensure the health and welfare of institutionalized residents.
ISDH	Indiana State Department of Health. This agency surveys facilities annually for compliance with federal guidelines and state rules for the purpose of evaluating quality of care.
ISMA	Indiana State Medical Association.

ITF	Integrated test facility. A copy of the production version of Indiana*AIM* used for testing any maintenance and modifications before implementing changes in the production system.
JCL	Job control language.
key field	Specific fields on the MDS that HCFA has designated for the State to permit data entry errors to be corrected by way of a special request form.
LAN	Local area network.
Level I	Indiana PASRR screening program to screen for depression. This must be done on every resident on admission.
Level II	Evaluation by a mental health professional for residents who exhibit signs and symptoms of a major mental illness and/or are receiving treatment such as medication for a major mental illness.
Level II Referrals	Residents identified by the auditors during their review that would possibly benefit by having a Level II screening performed.
LOC	Level-of-care. Medical LOC review determinations are rendered by OMPP staff for purposes of determining nursing home reimbursement.
lock-in	Restriction of a recipient to particular providers, determined as necessary by the State.
login ID	An eight-character string of numbers and/or letters that providers use to identify themselves to the BBS or the HCFA server.
LTC	Long-term care. Used to describe facilities that supply long-term residential care to recipients. Can be used synonymously with facility.
MAC	Maximum allowable charge for drugs as specified by the federal government.
MAI	Medicaid Audit Information form.
major error	An error that is so major the resident's status had been misrepresented on the MDS and the impact of the erroneous data is such that a correction is warranted.
MARS	Management and Administrative Reporting Subsystem. A federally mandated comprehensive reporting module of Indiana*AIM* that includes data and reports as specified by federal requirements.

master file	Comprehensive file of all Medicaid-certified LTC facilities at EDS.
MCO	Managed care organization.
MDS 2.0	Minimum Data Set 2.0. A core set of screening, clinical, and functional status elements, including common definitions and coding categories, that form the foundation of the comprehensive assessment for all residents of LTC facilities certified to participate in Medicare and Medicaid. The items in the MDS standardize communication about resident problems and conditions within facilities, between facilities, and between facilities and outside agencies. Additionally, it permits full coding of the RUG-III case mix payment system.
median allowable costs	A median is the middle number in a given array or sequence. Separate medians are calculated for each rate component (direct care, indirect care, administrative, and capital).
Medicaid fiscal agent	Contractor that provides the full range of services supporting the business functions included in the core and non-core service packages.
Medicaid in Process	A resident who has an IHCP number and all information has been sent to the State, but *Form 450B* is not back with an effective date and signature present.
Medicaid Pending	A resident who has applied for Medicaid but has not yet been approved and has not received an IHCP number
medical policy contractor	Successful bidder on *Service Package #2: Medical Policy and Review Services.*
MEQC	Medicaid Eligibility Quality Control.
MI	Mental illness.
mix	Refers to an additive measure of a combination of different individual profiles seen in a specific setting or facility.
MMIS	Medicaid Management Information System. Indiana's current MMIS is referred to as Indiana*AIM.*
MR	Mental retardation/mentally retarded.
NCPDP	National Council for Prescription Drug Programs.

NDC	National Drug Code. A generally accepted system for the identification of prescription and non-prescription drugs available in the United States. NDC includes all subsequent editions, revisions, additions, and periodic updates.
NECS	National Electronic Claims Submission is the proprietary software developed by EDS. NECS is installed on a provider's PCs and used to submit claims electronically. The software allows providers access to on-line, real-time eligibility information.
non-certified beds	Beds in a LTC facility that are not authorized or licensed for government reimbursement.
non-core contractors	Refers to the Medical Policy Contractor and the TPL/Drug Rebate Contractor.
non-core services	Refers to *Service Packages #2 and #3*.
NPIN	National Provider Identification Number.
NF	Nursing facility. A facility that provides residents with nursing care and related services for residents who require medical or nursing care, rehabilitation services, health-related care and services to individuals who because of their mental or physical condition require care and services.
OBRA	Omnibus Budget Reconciliation Act. In 1988, Congress mandated a national resident assessment based on the MDS.
OMNI	A point-of-sale device used by providers to scan recipient ID cards to determine eligibility.
OMPP	Office of Medicaid Policy and Planning.
OMRA	Other Medicare required assessment.
OSRA	Other State required assessment.
P.P./PVT	Denotes a resident who is paying for all expenses in a facility and who is not an IHCP recipient.
PA	Prior authorization. Some designated IHCP services require providers to request approval of certain types or amounts of services from the State before providing those services. The Medical Services Contractor and/or State medical consultants review PAs for medical necessity, reasonableness, and other criteria.

PAS	Pre-Admission Screening. Refers to the assessments and determinations required prior to facility admission or, if approved for temporary admission, completed within specific time frames following admission.
PASRR	Pre-Admission Screening and Resident Review. A set of federally required long-term care resident screening and evaluation services, payable by the Medicaid program, and authorized by the Omnibus Budget and Reconciliation Act of 1987.
PCCM	Primary Care Case Management. One of three delivery systems within the Hoosier Healthwise managed care program. Providers in PCCM are reimbursed on a fee-for-service basis. Members are assigned to a primary medical provider (PMP) or group that is responsible for managing the care of the member and providing all primary care and authorizing specialty care for the member—24 hours a day, seven days a week.
PDR	Physicians Desk Reference©. An annually updated list of medications that include generic names, makeup of medications (ingredients and chemical compounds), usage and indications, doses, side effects, and pictures of what the medication looks like.
per diem	Daily resident reimbursement rate of a Medicaid nursing facility resident. Per diem rates change quarterly.
PMP	Primary medical provider. A physician who approves and manages the care and medical services provided Hoosier Healthwise members linked to PMP.
POS	Place of service or point of sale, depending on the context.
PPO	Preferred provider organization.
PPS	Prospective Payment System. This refers to the Medicare reimbursement system.
PRO	Peer review organization.
Pro-DUR	Prospective Drug Utilization Review. The federally mandated, Medicaid-specific prospective drug utilization review system and all related services and activities necessary to meet all federal Pro-DUR requirements and all DUR requirements.
provider	Person, group, agency or other legal entity, that provides a covered IHCP service to a recipient.

provider number	The unique individual or group number assigned to practitioners participating in the Indiana Health Coverage Programs.
QDWI	Qualified disabled working individual. A federal category of Medicaid eligibility for disabled individuals whose incomes are less than 200 percent of the federal poverty level. Medicaid benefits cover payment of the Medicare Part A premium only.
QIs	Quality indicators. Information gleaned from all submitted MDS assessments, focusing on 24 areas of care, produce the quality indicators.
QMB	Qualified Medicare beneficiary. A federal category of Medicaid eligibility for aged, blind, or disabled individuals entitled to Medicare Part A whose incomes are less than 100 percent of the federal poverty level and assets less than twice the SSI asset limit. Medicaid benefits include payment of Medicare premiums, coinsurance, and deductibles only.
Quarterly Assessment	MDS assessment containing sections A-R is completed no less frequently than once every 90 days between annual full assessments.
RA	Remittance advice. A summary of payments produced by Indiana*AIM* explaining the provider reimbursement. RAs are sent to providers along with checks or EFT records.
RAI	Resident Assessment Instrument.
RAPs	Resident assessment protocols are explained in detail in the *RAI Manual*, Section 4. A component of the utilization guidelines, they are problem-oriented framework for organizing MDS information and explaining additional clinically-relevant information about an individual. RAPS help identify social medial and psychological problems and form the basis for individualized care planning.
RBMC	Risk-based managed care. One of three delivery systems in the Hoosier Healthwise managed care program. In RBMC, a managed care organization is reimbursed on a per capita basis per month to manage the member's health care.
RBRVS	Resource-based relative value scale. A reimbursement method used to calculate payment for physician, dentists, and other practitioners.
recipient	Person receiving IHCP services while eligible.

recommendation for discharge	Recommendation for discharge from a facility by auditors after thoroughly assessing a resident and investigating the resident's capabilities and outside resources available based on *405 IAC1-3-1* and *IAC1-3-2* criteria.
Record Type	An alpha character representing one of many different types of assessment records. The MDS 2.0 record type is based on the reason for assessment codes in items AA8a and AA8b
Resident Assessment Instrument	RAI Manual. Published by HCFA, the RAI consists of three basic components: the Minimum Data Set (MDS), Resident Assessment Protocols (RAPS), and Utilization Guidelines.
resident not seen	Resident not seen by the audit team while in the facility for the audit process.
resident roster	Case Mix Roster/Time Weighted Report. A report generated from the Indiana MDS 2.0 system listing the latest record for each resident in the facility. This report may be for a specific day or for a period of time (for example, for a quarter). Myers & Stauffer provides these rosters to the EDS LTC department and they are in audit packets.
resident seen	Refers to a resident who has been seen by the audit team in the facility but either does not have an effective date on the 450B or has a *Form 450B* in process at the OMPP.
resolves	Disposition of residents previously listed in the past year as IHCP recipients. The date of the resident's change in status and what occurred to cause the change in status.
RFI	Request for Information.
RFP	Request for Proposals.
RHC	Respirations have ceased.
RID number	Recipient identification number.
RUG	Resource Utilization Group. A resident classification system that identifies the relative costs (resource cost) of providing care for different types of residents in nursing facilities based on their resource use.
RUG-III	Version Three (III) of the Resource Utilization Group. All Medicare records will be classified using RUG Grouper version 5.12 and all IHCP records will be classified using RUG Grouper version 5.01.
RUG-III class code	An abbreviation of each RUG-III classification category.

RUG-III classification code	A category-based classification system in which nursing facility residents classify into one of 44 RUG-III groups. Residents in each group use similar quantities and patterns of resource. Assignment of a resident to a RUG-III group is based on certain MDS 2.0 responses.
SCSA	Significant change in status assessment.
SDX	State Data Exchange System. The Social Security Administration's method of transferring SSA entitlement information to the State.
shadow claims	Reports of individual patient encounters with a managed care organization's (MCO's) health care delivery system. Although MCOs are reimbursed on a per capita basis, these claims from MCOs contain fee-for-service equivalent detail regarding procedures, diagnoses, place of service, billed amounts, and the rendering or billing providers.
significant change	A major change in a resident's status that is not self-limiting, impacts more than one area of resident's health status, or requires interdisciplinary review or revision of the care plan.
SLMB	Specified low-income Medicare beneficiary. A federal category defining Medicaid eligibility for aged, blind, or disabled individuals with incomes between 100 percent and 120 percent of the federal poverty level and assets less than twice the SSI asset level. Medicaid benefits include payment of the Medicare Part B premium only.
specialty vendors	Provide support to IHCP business functions but the vendors are not currently IHCP fiscal agents.
SPR	System performance review.
SSA	Social Security Administration of the federal government.
SSI	Supplementary Security Income. A federal supplemental security program providing cash assistance to low-income aged, blind, and disabled persons.
State	Refers to the State of Indiana and any of its departments or agencies.
subcontractor	Any person or firm undertaking a part of the work defined under the terms of a contract, by virtue of an agreement with the prime contractor. Before the subcontractor begins, the prime contractor must receive the written consent and approval of the State.

SUR	Surveillance and Utilization Review. Refers to system functions and activities mandated by the Health Care Financing Administration (HCFA) that are necessary to maintain complete and continuous compliance with HCFA regulatory requirements for SUR including the following SPR requirements: • statistical analysis • exception processing • provider and recipient profiles • retrospective detection of claims processing edit/audit failures/errors • retrospective detection of payments and/or utilization inconsistent with State or federal program policies and/or medical necessity standards • retrospective detection of fraud and abuse by providers or recipients • sophisticated data and claim analysis including sampling and reporting • general access and processing features • general reports and output
systems analyst/engineer	Responsible for performing the following activities: • Detailed system/program design • System/program development • Maintenance and modification analysis/resolution • User needs analysis • User training support • Development of personal Medicaid program knowledge
TANF	Temporary Assistance for Needy Families. A replacement program for Aid to Families with Dependent Children.
TBI	Traumatic brain injury.
TPL	Third Party Liability.
TPL/Drug Rebate Services	Refers to *Service Package #3: Third-Party Liability and Drug Rebate Services*.

UB-92	Standard claim form used to bill hospital inpatient and outpatient, nursing facility, intermediate care facility for the mentally retarded (ICF/MR), and hospice services.
UCC	Usual and customary charge.
UPC	Universal product code. Codes contained on the First Data Bank tape update and/or applied to products such as drugs and other pharmaceutical products.
UPIN	Universal provider identification number.
utilization guidelines	The regulatory term for instructions concerning when and how to use the RAI.
Validation Report	An electronic file that contains detailed information about MDS assessments transmitted. Validation files are in a provider's download directory.
VFC	Vaccines for Children program.
VIP	Validation Improvement Plan. A plan of correction sent to a facility following a case mix audit where the facility rate falls below the established validation threshold. Facilities are sent a findings letter from EDS that includes the VIP, if applicable. The facility has 15 business days to return the completed VIP to EDS.
WAN	Wide area network.
WIC	Women, Infants, and Children program. A federal program administered by the Indiana Department of Health that provides nutritional supplements to low-income pregnant or breast-feeding women, and to infants and children under five years old.

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